Amend #22, nls, per fd, 06/03/08, Allegany Co. For

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008

8	2	0	5	0

			State Registrar			Cert	ificate	of L	Death			Reg. No.			
			1. Decedent's Name (First, Middle, La	st)							2. Date of Do Month	eath Day	Year	3. Time of Death	
•	Physici /Medi		BYRON LEE	VALENT	INE								2008	1:00 A.M	J
E.	Examir		4a. Facility Name (If not institution, give	e street and nun	nber)		4b. City, To	wn, or	Location	of Death			nty of Death		
d			699 GEPHART	DRIVE			CUM	1BE	RLAN	ID		AI	LEGAN	1Y	
	Funeral		Social Security Number 6. S		7. Age (In yrs. last birti		If Under 1		If Under		8. Date of Bi	rth	9. Birthp	place (State or Foreign htry)	n
ы	Director		218-30-0320	M 2□F	70	rs.	Months Days Hours Min. (Month, Day, Ye SEPT • 24						7 MÃ	RYLAND	
	ъ		Usual Residence of Decedent											_	
	ylan Jow at		10a. State 10b. County		10c. City, Town	or Loca	ation						1	10d. Inside City Limits	
	the Marylar 28a-f show notified at	ţò	MD ALLEG	ANY	CUMBE	RLA	ND							1XX Yes 2 ☐ No	1
	7.28g	ire	10e. Street and Number				10f. Zip C	ode				10g. Citizen	of What Coul	ntry?	
	3a o	0	699 GEPHART DRI	VE			21	502				U.S	•A•		
	ms 2	Funeral Director	11. Marital Status		dent Ever in U.S.	13. W	as Deceder	nt of Hi	spanic Or	igin? (Spe	cify Yes or N Rican, etc.)	0- 14.1	Race - Americ		_
10	r ite	Ē	1 ☐ Never Married 2 🙀 Married	Armed Fo 1 XYes If Yes, Giv		1					(ican, etc.)		Black, White,	etc.	
93	al", o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	ates: 157-159	11	∐Yes 2	No.	Specify:			Spe	ecify: WI	HITE	
5-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	Completed by	15. Decedent's E	ducation	16a.	Decede	nt's Usual (Occupa	ation	nd nd complete		16b. Kind o	f Business/In	dustry	
718	in 7 in "in Medi	용	(Specify only highest grant Elementary/Secondary (0-12)	College (1	-40r 5+)	life. Do	ind of work O NOT use	retired))	St OF WORKE	ig	1			
2121	filed within a Hygiene. Other than "rent, the Medent, the Med	E	12		,	DRI	VER					TRA	NSPORT	ATION	
D	othe othe	Be	17. Father's Name (First, Middle, Last	")					18. Mothe	er's Name	(First, Middle	e, Maiden Sur	name)		
<u>a</u>	ould be Mental arked o	To B	(UNKNOWN)						WAI	NETTA	VALI	ENTINE			
Maryland	2 should and Men is marke sumatic		19a. Informant's Name/Relationship	Type. Print)	19b.	Mailing	Address (S	Street a	and Numb	er or Rura	l Route Num	ber, City or To	wn, State, Zij	o Code)	
Š	C/ 10 m 10		LANA VALENTINE	/ WIFE		699	GEPH	ART	DRI	VE, C	UMBERI	LAND, M	D 215	502	
ē,	ges 1 and 2 t of Health If Item 27 or other tra		20a. Method of Disposition		20b. Place of	Disposi	ition (Name	of	-)	D	ate	20c. Location	on - City or To	own, State	_
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐		State		atory or other		1	6/04	/2008	 ET.TE	VISTON	F. MD	
Ē	it. Purtme		4 ☐ Donation 5 ☐ Other (Special Service Lice		M.S.V.	1	Name and				HOME	LUII	115101	E, 11D	_
Ba	permit. Page Department of Important: If any injury or once.		1 kg and D	While	11)	1	UPCHU	RCE	FUN.	ERAL-	OME; I	P.A.		21 502	
			23a. Part1. Enter the disease, or con			-11						BERLAND	, MD	21502	
			shock, or heart failure. List only	one cause on e	ach line.	ot enter	the mode	oi uyiii	y, sucri as	Gardiac O	riespiratory	arrest,		Approximate Interval Between Onset and Death	
N	Physician		Immediate Cause (Final disease or condition	_a	ukenia									1 year	~
4	/Medical Examiner		resulting in death)	Due to (or as a consequence o	f):								,	
	Examine		Sequentially list conditions.	b											
	D #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence o	f):									
	ecute and tran-	if any, leading to immediate cause. Enter Underlying Cause Universe or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												_	
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68760,	certificate be executed ding physician and se as the burial-transit	/Medical		_ d											_
9	certific iding p	Me	IF FEMALE:										-		
Вох		1 = 1	23b. Was decedent pregnant in the past 12 months?	1 Live b	come pf pregnancy irth 2 ☐ Fetal death		Ectopic preg					23d.	Date of deliv Month	ery Day Year	
	e de	Sic	1 ☐ Yes 2 ☐ No	4⊡Pregn 9⊡Unkno	ant at time of death	5 🗆	Other (spec	ify)							
P.0	The law requires that the death (te has been signed by the atten age 2 should be detached for u	Physicia	9 Unknown								00 - Did			No	_
	w requires that s been signed to should be deta	by	Part II. Other significant conditions	contributing to de	eath but not resulting in	tne und	enying cau	se give	en in Part	1.				the cause of death?	
or Vital Records,	equir en s										1]Yes 2□ N	o 3∏Pro	bably 4 Unknow	Л
ပ္ပ	law ras be	Completed									24a. Wa	s an 2	4b. Were aut	opsy findings available	е
ď	sician: The law certificate has t irector, page 2 s	E										formed?	death? 1 ☐ Yes	•	
ta	an: tifica tor, p		25. Was case referred to medical						26. Place	e of Death	(Check only				_
>	Physician: The this certificate hiral director, page	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2 ☐ ER/Out	patient	3□ DOA	Oth	DF:			sidence 6	Other (Speci	ify)	
	g Physer this eral dii	ᆵ	27. Manner of Death	28a. Date	of Injury 28b. T	ime of		. Injur Worl				how injury of		.,,,	
o	nding F th. : After e funera	ţi	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	,	h, Day Year) Ir	ijury	М		<br Yes 2 □	No _					
Division	Attending r death. ector: After y the fune	fica	3 Suicide 6 Could not b	Zoe. Flace	of injury - At home, far	m, stre	street, factory, office 28f. Location (Street and Number or Rural Route					ral Route Number,			
	i or A after Dire	Certification:	4 Homicide determined determined building, etc. (Specify)												
	ospital hours uneral	C	29a. Certifier 1 ☐ Certifying P	hysician: To the	best of my knowledge	death	occurred at	the tir	ne, date a	nd place, a	and due to th	e cause(s) an	d manner as	stated.	_
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	edical		miner: On the b	asis of examination and ner stated.										
	To the H within 24 To the Fi	Me	29b. Signature and title of certifier		1 1		29c. I	Licens	e num ber			29d. Date si	gned (Month	, Day, Year)	_
1/1 mul 5 - May.						'aı -	11.1.			J.	D 21502				
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	Thes		30. Name and address of person who	Danniered caus	o lucam (nem 23a) (U 1	Sition	7	ino	Con	barlo	and Mi	D 21	500	
		ate	31. Date filed (Month, Day, Year)	1 3 R	egistrar's Signature	10	11001	٠1,	100	UUI	DEN 12	WIN 101	J 307		_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20502 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Morris H. Willey 06:15 PM M June 10, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1183 Pocahontas Rd Garrett Frostburg Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Days Min. Hours 1**X**M 2□ F 213-58-4122 57 December 01, 1950 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 Yes 2 No Maryland Garrett Frostburg Director 10e. Street and Number 1183 Pocahontas Road 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ò 3 ☐ Widowed 4 ☐ Divorced White al Hygiene. other than "natura vent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registrar Education 1 and 2 should be filed w Heafth and Mental Hygier em 27 is marked other th ther traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morris Lee Willey Lucy Nance 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: if item 27 is
any injury or other trau Victoria Willey 1183 Pocahontas Road 21532-Maryland Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State June 11, 2008 **Cumberland Crematory** Cumberland Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 ohn 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 mos Physician naulia nant disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed and burial-trar Due to (or as a consequence of): signed by the attending physician I be detached for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 (No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I.

20 mes

State

Registrar

Medical

29b. Signature and title of certifier

and manner stated

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

H0065454 Michele Kennedy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29a. Certifier

JUN 1 2 2008

State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Woodfork 2008 a M 6:00 Jacqueline June 4 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, January Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🗗 F 66 1942 Washington, DC Director 579-58-7730 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heaith and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is indicated. 10a, State 10b. County 10c. City. Town or Location 10d, Inside City Limits MD MONTGOMERY SILVER SPRING Director 1 XYes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1316 FENWICK LANE #1207 20910 USA Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7TH College (1-4or 5+) DISABLED NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WOODFORK ROUZIE HENRY MARY ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1316 FENWICK LANE #1207, SILVER SPRING, MD 20910 MARY WOODFORK/ MOTHER 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State FT. LINCOLN CEMETERY : 06/12/2008 BRENTWOOD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME 21. Signature of Funeral Service 716 KENNEDY ST. NW, WASHINGTON, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INTUSSUSCEPTION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CARDIAC ARREST Sequentially list conditions Examiner Due to (or se a consequence of) if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 🗓 No for Month Day Year Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 sign I be BREAST CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No or Attending Physician: The 2 No 1 □Yes 1 □ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∭XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending Injury after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Funeral C Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number JUNE 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIA D'ARBELLA 1500 FOREST GLEN RD., SILVER SPRING, MD 20910 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician JUNE 200^{Year} 9, 4:33 P M KATHERINE ANNA /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav Social Security Numb 6 Sex Pennsylvania **Funeral** 166-48-9438 Months Days Hours Min. March Day, 1 □ M: 51 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 10a. State XXYes 2 No **Maryland** Frederick Brunswick Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or Items 23a or Examiner must be USA 21716 817 East Potomac Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ❤️ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itea may hijury or other traumatic event, the Medical Examine one. 1 Never Married 2 Married 1 ☐ Yes X No Baltimore, Maryland 21215-0036 Specify: Specify White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheetz 3+ Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewin John Snyder Betty Jean Smith 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley White (Husband) 817 E. Potomac Street, Brunswick, Maryland 21716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6/16/08 Burial 2 ☐ Cremation 3 ☐ Removal from State Williamsport, Maryland Greenlawn Memorial Park 4 □ Donation 5 □ Other (Specify) T. Indistantion 22. Name and Address of Facility Lochstampfor Funeral Home, Inc. 48 S. Church Street, Waynesboro, PA 17268 21. Sign ture of Fur 23a. Part1. Enter the disease, or complications that cause of the death. Do shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): minutes **Physician** /Medical Examiner gronery Sequentially list conditions, if any, leading to in include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 3 Probably 1 🗌 Yes 2 No 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was ... autopsy performed ves 2□ No 1□ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Inpatient ER/Outpatient 3 DOA 1 ☐ Yes 2 this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. I Director: After the in by the funeral 27. Manner of Death Certification: (Month, Day Year) Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

OSH-12

31. Date filed (Month, Day, Year) JUN 1 2 2008

29b. Signature and title of certifier

HUSSAIN ·M

Hunsin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D4686

29d. Date signed (Month, Day, Year)

TJ Drive Frederick MD 21702

State

Registrar

20505 State of Maryland / Department of Health and Mental Hygiene [] [] 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician Month Rocelia Fitzgerald Wilson June 8,_ 2008 0307 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 85 New Bridge Road Rising Sun Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**K** F 219-34-0039 69 Director Dec. Maryland Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 85 New Bridge Road 21911 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔼 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🖾 No <u>^</u> Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Fitzgerald Mary Reynolds P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cornelius Wilson 85 New Bridge Road, Rising Sun, Maryland 21911 (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Brookview Cemetery 06/12/08 Rising Sun, Maryland 4 □ Denation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Perryville, Maryland 21903-0766 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Muscardin **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident completely filled in by the I 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who comp cause of death (Item 23a) (Type, Print) 2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** Z:08 PM Robert Glenn Webb 06 08 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salis Wicomko Coasta Hospice Lake bury If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F 219-34-4064 Director 69 Maryland Nov. 6, 1938 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7911 Jones & Hastings Road U.S.A. Funeral 21849 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21XXNo Specify: Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Owner & Operator Trucking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown ပ Alma Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Ellen Webb (wife) 7911 Jones & Hastings Road Parsonsburg, MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buria! 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Line Cemetery June 12, 2008 Delmar, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home
13 E. Grove Street Delmar, DE 19940 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear interest interest. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MRTASTATIC CARCINDAYA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2/2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at

Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev

Physician

/Medical

Examiner

burial-tran

After this certificate has funeral director, To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; At completely filled in by the fu Medical

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EHUIAM WARY 31. Date filed (Month, Day, Year) JUN 1 0 2008 Registrar

29b. Signature and title of certifier

COASTAL Registrar's Signature

and manner stated

6.0 Dox 1733 SALISBULY NO 21802

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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/Med Exami		4a. Facility Name (If not institution, give street and number HOWARD (D: GENERAL	Hospital 3	City, Tayon, or Legation of Death		County of Death Co.
Funera Director			Age (In yrs. last birthday) If	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Country) 125 U.S. Virgin
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e Mary 3a-f sh e	ctor	VIRGINIA	New porT	News		1 ☑Yes 2 ☐ No
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IOTE, Maryland 21213-UU36 ges 1 and 2 should be filled within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exprimer must be notified at	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 20 1f Yes, 30 Year or Date	X No 1 □	Decedent of Hispanic Origin? (Sis, specify Cuban, Mexican, Puerto Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
Z1Z15-UU36 d within 72 hours af giene. er than "natural", or the Medical Evani	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give kind	's Usual Occupation f of work done during most of work NOT use retired)	king	Kind of Business/Industry
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, Maryland and 2 should be file saith and Mental H) 27 is marked oth er traumatic eveni		19a. Informant's Name/Relationship (Type. Print) EMILE A. WAIKER	19b. Mailing A 9608 /	ddress (Street and Number or Ru	ral Route Number, Cit FCRT Bell	y or Town, State, Zip Code) VOIR, VA 22060
Saltimore, Sermit. Pages 1 a Department of He mportant: If item any Injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te 20b. Place of Disposition cemetery, cremato	in (Name of try or other place) Find (ComeTens DG	Date 20c.	louces Ter, UA
Baltimo permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service License 11 16	22. No. 261	ame and Address of Fallity A	RTER FUN Newber	eral Home Inc
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To the vithin To the comp	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
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St Regist	ate trar	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	E)		1

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State Registrar

31. Date filed (Month, Day, Year) JUN 2 5 2008

SURENDRA



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21701

Frederick, MD

			For State Registrar		State of Ma	arylanc	i / Depa <i>Cei</i>	artment of F r <i>tificate of</i>	lealtr Deat	n and M <i>h</i>	ental Hy	giene Reg. No.		20509
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Ł.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 10 10 10 10 10 10 10 1										9. Birth	pplace (State or Foreign
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5	Physicle this cert al direct	25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										eify)		
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	1401		30 Name and addre	ess of person who	completed cause of de	eath (Item :	23a) (Type,	Print) 1900 Lock	Ra	VEN B	Wd P) 4 L+,	more N	11 2218
ì	Sta Registr	te ar	31. Date filed (Mont	th, Day, Year) UN 2 5 20	32 Registra	ar's Signati	ile V	whi .			-, .		1 - Part 1	2008 10 22/8

State of Maryland / Department of Health and Mental Hygiene 2008

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 22, 2008 **Physician** June A. Bachman-Krug 8:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2024 Grinnadls Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6/22/2008 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2X F @!¢_@\$_(@&¢ Director Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at MD 1 ▼Yes 2 No Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2024 Grinnadls Avenue 21230 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LeRoy Warthen Dora Bealefeld 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 | other tra Linda D. Shewell / Daughter 1531 Tieman Dr., Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 6/25/2008 | Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ROKE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last r as a consequence of) the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🕱 No 9☐Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 | Yes 2 (No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 23, 2008 021649 Unkaras_40 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AASKARAN, 3455 WILKENS AVE BALTIMORE, MD 21229 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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Physicia		Registrar 1. Decedent's Name (First, Middle	,Last) .					2. Date of Deat	h	3. Time of Death			
dical Exami	ner	Annette E						Month June 20, 2		0744 hrs			
		4a. Facility Name (if not institution Memorial Hospital of E.	. 0	er)	4	b. City, Town, or L	ocation of De	eath	4c. County of D	eath			
Francis				ae (In vre I	ast birthday)	Ridgely If Under 1 Year	If Under 24	Hre 8 Date of Birt		Birthplace (State or			
Funeral Director						Months Days		Min.	Fo	reign Washington			
		214-52-4977 Usual Residence of Decedent	1M _2XF	6	Yrs.	<u> </u>	<u> </u>	May 5,	1947	D.C.			
any		10a. State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits			
nd show	٦	MD Carol	ine	R	idgely					1 XXYes 2 No			
Aaryla 28a-f I at oi	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What	Country?			
ith the Maryland : 23a or 28a-f show s	直	117 Walnut St	reet			216	60		USA				
h with	Funeral	11. Marital Status 1 Never Married 2 X Mar	12. Was Decede			Decedent of Hispans, specify Cuban,		(Specify Yes or No-	14. Race - A	merican Indian, Black, c.			
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5-0036 led within 72 Hygiene. other than '	Completed	12th	ø		Inst	ructional	l Assi	stant	School	-			
215-0036 be filed within 7 tal Hygiene. ked other than ent, the Medica		17. Father's Name (First, Middle, L	ast)					ime (First, Middle, N					
121 d be fi ental arked	Be	George Zoi:			-		Alma	Godbout					
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ြ	19a. Informant's Name/Relationshi				,			ber, City or Town, S	tate, Zip Code)			
and 2 she ealth and tem 27 is traumat		Clarence L. Bla	ir/Husband	20b. 1		Walnut St		Ridgely, Date	MD 2166 20c. Location - Cit				
Baitimore, semit. Pages I ar Department of Hee Important: If iten injury or other tr		1 XX Burial 2 Cremation	3 Removal from	State	crematory or oth	er place)							
it. Partmen		4 Donation 5 Other Special Service L		Co		Memorial		/28/2008		ille, MD			
Ba perm Depa fmpc		2 man of	DOOK) MOI					Funeral H				
Physician		23a. Part I. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
/Medical Examiner				romboem	ıbolism					Between Onset and Death			
Exammer		r condition resulting in death) Due to (or as a consequence of):											
	-	Sequentially list conditions, If any, leading to immediate b. Bilateral deep vein thrombosis Out to (or as a consequency of):											
بسب	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	c.	is source in the S	.,								
\90 f =	Та	events resulting in death) Last	Due to (or as a cor	nsequence o	f):								
executed an and al - transit	dical	UNPENDED	d. AMENDED										
50, te be exi sysician burial	ledi	IF FEMALE:	23c. If yes, outo	ome of pred	nancy				23d. Date of del	verv			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	sician/Me	23b. Was decedent pregnant in the past 12 months?		one or preg		al death 3	Ectopic pre	gnancy	Month	Day Year			
DX 6 ath ce attend or use	Sici	1 Yes 2 V No 9 Unkr	4 Pregnant	at time of	5 Oth	er (Specify)							
the de	Phy	Part II. Other significant condition	9 OHKHOWH	ath but not re	esulting in the ur	nder(ving cause oi)	ven in Part I.	23e. Did to	bacco use contribut	e to the cause of death?			
P.O.	ð	Status post abdomino	_		g	,		1 Yes	2 No 3	Probably 4 🗸 Unknown			
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tal Rectian: The		25. Was case referred to medical	1		• · · · ·	26 Place o	of Death (Che	1 Yes	2 No 1 🗸	Yes 2 No			
Division of Vital ral or Attending Physician: rs after death. al Director: After this certiled in by the funeral director	o Be	examiner?	Hospital: 1 Inpa	tient 2 🗸	ER/Outpatient	10	Othor:	rsing Home 5	Residence 6 0	Other:			
of \ ig Ph; ther therefore the present the	-	27. Manner of Death	28a. Date of I (Month, Da	njury	28b. Time of In	jury 28c. Injury	at Work?	28d. Describe	now injury occurred				
On tending or: A	Certification:	1 Natural 5 Pendi		y, i bai j		1 Ye	es 2 No						
Vision or Attenditer death Director:	ific			Injury - At h	ome, farm, stree	t, factory, office bu	ilding, etc.	28f. Location (S or Town, S		r Rural Route Number, City			
Dj spital nours a neral I	Cert	4 Homicide deterr	mined (Specify)										
To the Hos within 24 h To the Fur completely		29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of niner:On the basis of e	my knowled	ge, death occurr	ed at the time, dat	e and place,	and due to the caus	e(s) and manner as and place, and due	stated.			
To the To the Comp	Medical	29b. Signature and title of certifier	and manner state	d. 1		29c. License				(Month, Day, Year)			
	2	255. Signature and title of certifier	—	1		O.C.M			June 21, 200				
^<		MININ	W/	f dooth (lta-	232)								
25		Name and address of person value. Zabiullah Ali, M.D.	who completed cause o Assistant Medical			n Street, Baltir	nore, MD	21201					
s	tate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signati	- 4	60 n							
Regis		JUN 2 5	2008	de de	ure .	Charles of the Contract of the		2014					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ye ar Month **Physician** 905 June 2008 23 MON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore If Under 1 Year | If Under 24 Hrs. Samaritan Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** N. Carolina 1 □ M 2 □ ✓ 17 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examine must be notified at 10a. State 10b. County 1 Yes 2 No Director MD 10g. Citizen of What Country? 10e. Street and Number by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cool Cool 19a. Informant's Name/Relationship (Type. Print) altimore, 20c. Location - City of . Method of Disposition

Method of Disposition

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) rson forest 21. Signature of Funeral Service Licenses m01363 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode state shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage -iver Disease **Physician** /Medical Due to (or as a consequence of): Examiner patitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burian Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2 No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ oagulopathy 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 100 24 hours after death.

Funeral Director. After this certific etely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 23, 2008 D0058141 Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MP Blvd Loch 5601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 5 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death

4b. City, Town, or Location of Death

3. Time of Death 2 10A M

4c. County of Death

Physician /Medical Examiner

Director

Funeral

2

Completed

Be ပ 1 - For State Registrar

Samuel Withers Brumbaugh

4a. Facility Name (If not institution, give street and number)

Funeral Director

with the Marylan 28a-f show be notified at ò ms 23a items 2 permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Innortant: If item 27 is marked other than "natural", or item any Injury or other traumatic event, I'm Medical Exant Baltimore, Maryland 21215-00

BRUMBAUGH

Physician /Medical Examiner

Examine burial-trar Physician/Medical attending physical signed by the a ₹ cate has been signated by page 2 should b Completed certificate ors after death.

eral Director: After this certifica filled in by the funeral director, I Be Certification: To

Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Lanham Doctors Community Hospital Prince George's Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Hours Min. Months Davs 1**⊠** M 2□ F 578-40-3805 10/12/1930 Washington, D.C Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No MD Prince George's Lanham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9405 Dubarry Avenue 20706 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1953 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify 3 ☐ Widowed 4 ☐ Divorced 1961 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 Agent C.I.A. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Brumbaugh Lvdia Withers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley S. Brumbaugh, Wife 9405 Dubarry Ave., Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 6/28/2008 Brentwood, MD Lincoln Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Hyattsville, MD 20781 · lon Vas Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infried at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Durato for as a purseculence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2000 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sigr re and title of c 29c. License number 29d. Date signed (Month, Day, Year) rtifie on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per 0 Ann 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 2 2008 5

within 24 hours a

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completely

Medical

State

Registrar

			For	State of Marylar	nd / Depa	artment of H	lealth an	d Mental Hy	giene				
			1 - State Registrar		Ce	rtificate of	Death		Reg. No. 200	8 20514			
	Physici	an	1. Decedent's Name (First, Middle, Last	")				2. Date of De Month	Day Year	3. Time of Death			
g. N . y	/Medic	al	Phyllis C. Baml 4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of D		23/2008 4c. County of De	11:20 P M			
1000	Examin	er	Sacred Heart Home	street and number)			attsvil		,	George's			
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.			If Under 24 I			irthplace (State or Foreign			
	Director		522-28-4558 Usual Residence of Decedent		33 Yrs.			6/26/1	925 La	ke City, CO			
yland	show		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits			
e Mar	a-f sh tiffed	ctor	FL Leon			Tallaha	ssee			1 ☐Yes 2 No			
vith th	a or 28 be no	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What (·			
leath v	ns 23a must	Funeral	2112 Orleans Driv	7e 12. Was Decedent Ever in L	J.S. 13.		32308 Hispanic Origin?	? (Specify Yes or No	U.S. - 14. Race - An				
after d	or Iten niner		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				? (Specify Yes or No uerto Rican, etc.)		nite, etc.			
filed within 72 hours after death with the Maryland	uraf", d	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No			Specify:	White			
n 72 h	"natur edical	Completed	15. Decedent's Edi (Specify only highest grad	le completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of ed)	working	16b. Kind of Busines	s/Industry			
withi	r than	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)		ninistrat			Federal P	rison System			
e file	Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at once.	Be C	17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Surname)				
y a	Ment narked	ဥ	Thomas Creel		T				ifred Read	*			
d2sh	th and 7 is n traun		19a. Informant's Name/Relationship (T	,,,					er, City or Town, State	•			
s t an	f Heal Item 2 other		20a. Method of Disposition			osition (Name of ematory or other pla		Date	e, MD 2078				
Page	int: If		1 ☐ Burial 2 M Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specify</i>	Removal from State		an Cremator		/25/2008	Alexandri	a, VA			
amit.	Departn Importa any Inju once.		21. Signature of Funeral Service Licens	see /		2. Name and Addre	ess of Facility			timore Avenu			
ā	으트등리		A Conslanz 23a. Part1. Enter the disease, or comp	e Dasel						11e, MD 2078			
DI-			shock, or heart failure. List only o	one cause on each line.		ner the mode of dy	ng, such as car	rolac or respiratory a	rrest,	Approximate Interval Between Onset and Death			
	ıysician Medical		disease or condition resulting in death)	a. Ovarian Car						l year			
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ath ce	attending p for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet	al death 3	Ectopic pregnand	;y		23d. Date of o	lelivery Day Year			
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a law I	2 33	Completed						24a. Was	psy prior t	autopsy findings available o completion of cause of			
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9 E	fer thi												
tendir	the fu	catio	1 ⊠ Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be 28e Place of injury. At home farm street factory office. 28f Location (Street and Number of Rum										
or At	after d Direc	Certification:	4 Homicide determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, st ify)	treet, factory, office			Street and Number or wn, State)	Rural Route Number,			
spita	nours neral y filled			ysiclan: To the best of my kn									
To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examone)	iner; On the basis of examin and manner stated.	ation and/or i			occurred at the time	, date and place, and c	lue to the cause(s)			
Tot	To 1	Σ	29b. Signature and title of certifier	J. f. 0		29c. Licen	se number	3	29d. Date signed (Mo	onth, Day, Year)			
•	,		Xuluali	· Cul	# 100-1 /Tim-	Print)	700	1	June 24,	2008			
(0		30. Name and address of person who can Raman R. Tuli, M.				Suite 20)2, Gaithe	ersburg, MI	20878			

DHMH 17 Rev 1/2001

State Registrar

08-04772	
Kevva D. Bluitt	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate		Reg	_{3. No.} 200	8 2051			
Physician ledical Examine		Г		2. Date of Death Month June 20, 20	Day Year	3. Time of Death 2154 hrs			
	4a. Facility Name (if not institution, give street and no University Hospital	umber)	4b. City, Town, or Location Baltimore	of Death	4c. County of Death				
Funeral Director	5. Social Security Number 6. Sex 466 37 8037 1X M 2 F	37 8037 1 X M 2 F 35 Yrs. Months Days Hours Min. Oct.8,19							
v any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc				10d. Inside City Limits			
Aaryland 28a-f show Latonce	MD N/A 10e. Street and Number	BAL	rimore		CIV CIA!! C	1 X Yes 2 No			
the y		unit H	10f. Zip Code 21225	U	9. Citizen of What Coun	ry?			
fler death with ", or items 23 er must be no		orces?	Vas Decedent of Hispanic Or f Yes, specify Cuban, Mexical Yes 2 X No specify	n, Puerto Rican, etc.)	14. Race - Americ White, etc.				
hours after natural", c		de completed) 16a. Deced	ent's Usual Occupation (Give most of working life, DO NO	e kind of work done	16b. Kind of Business/Ir				
136 hin 72 e. than "	Elementary/Secondary (0-12) College (1 11 th	1-4 or 5+)	ORER	,	WAREHOUSE				
21215-00 uld be filed with Mental Hygien marked other revent, the Mental Hygien revent r	DOLLCT'AS CROM			er's Nama (First, Middle, M URELIA BLU					
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and 2 sho lealth and item 27 is traumati	AURELIA WILSON /MOTE 20a. Method of Disposition		03 SEABURY osition (Name of cemetery,		MD. UNIT				
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I Important: If item 27 Impury or other traumarite	1 Donation 5 Other Specify:	TRINIT	Y CEM.	June 27,2	008 BALTI				
Bal permi Depa Impo Injur	21. Sin alure of Funeral Socretor Licens	(2)	Name and Address of Facili ALVIN B. SC.	RUGGS FUNE	RAL HOME	1213			
Physician /Medical	23a. Fant I. Enter the disease, or complications that failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot W.	aused the death. Do not ente	r the mode of dying, such as	cardiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death			
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30x death death of affor us	1 Yes 2 No 9 Unknown 9 Unknown	nant at time of death 5	Other (Specify)						
P. C		o death but not resulting in th	e underlying cause given in F		acco use contribute to t 2 ✓ No 3 Prob				
Records, The law require: ficate has been sig				24a. Was a autops	n 24b. Were aut	opsy findings available ompletion of cause of			
Reco The lav icate has				perform	ned? death?				
Vital Reorgisms: The his certificate director, page	25. Was case referred to medical examiner?		Othor	h (Check only one)					
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	To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
To COI	and manner s 29b. Signature and title of certifier	stated.	29c. License numbe	er	29d. Date signed (Mon	th, Day, Year)			
	IM.	16	O.C.M.E.		June 21, 2008				
	30. Name and address of person who completed cau Jack Titus MD. Deputy Chief Medi	, , , , , , , , , , , , , , , , , , , ,	enn Street, Baltimore,	, MD 21201					
Sta Registra		Signatur							

State Registrar

State of Maryland / Department of Health and Mental Hygien 2008

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year - ONAM **Physician** Srown 2008 ola /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Brook Genesis Hammonds ani Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 88 1 ☐ M 2 🔀 F 135-24-0083 1 orida Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 THES 2 NO Baltimore Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21230 Itams 23a 2658 orlan filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 le marked other then ' ury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) (rovernmen ietician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jac 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto dunghter 2658 Norland Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If eny injury or once. Cemete. muscus Name in the Me Curtien. 21. Sign Jan of Funeral Service Licensee ISENVICE F.A. sti 1701 Dow 23a. Part 1. Enter the disease, or complications the clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a A consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ZÑo 9 ☐ Unknown 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? certificate Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1/ Natural 5 Pending 1 ☐ Yes 2 ☐ No М death. investigation I Director: / 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours 6 To the Funeral C propertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifler 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 901 Donni M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

08-04745 Jin Chen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 20518

			- For State			•		Certifi	cate of	Death					Reg. No.		- 0 0		2001
Ph	ysicia	n/	Decedent's Name	(First, Middl	e,Last)									Date of De Month	Day	Ye			of Death
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124			4a. Facility Name (if 405 Vista W		n, give s	street and nu	ımber)			ь. City, To Fort W					Ī	Prince	George		
Fui	neral	T	5. Social Security Nu	ımber	6. Sex		7. Age (li	n yrs. last b	oirthday)	If Under Months		If Under Hours	24Hrs. 8 Min.	B. Date of E	Birth(MM	I/DD/YYY 	Y) 9. Birth Foreign	Maca (nland
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	x		Usual Residence of	Decedent			110	o City Toy	wn or Locati	00					_			10d. In	side City Limits
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it th	23a notif		2409 Benn 11. Marital Status	ing Ko		N.C. 12. Was De	cedent Ev	er in U.S.	13. Wa			anic Origi	n? (Spec	ify Yes or N	ify Yes or No- 14. Race - American Indian, Black,				ian, Black,
eath w	items ust be	uneral	1 X Never Marrie	d 2 N	arried	Armed F			If Y	es, specify	Cuban,	Mexican,	Puerto Ri	can, etc.)		CK	inëse	\Ama	rican
ifter d	l", or	by F.	3 Widowed	4 Div	orced If	Yes, Give Ye		140	1 🔲	Yes 2	No	specify:				Specify			
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16 n 72 l	ical E	Completed	Elementary/Seco	ndary (0-12)			1-4 or 5+)									Priva	ate		
	grene. her th	E I	17. Father's Name (12 First Middle	Last)	0		1	<u>elive</u>	rymai		8. Mother's	s Name (F	First, Middle	, Maide	n Surnam	ne)		
215 e filed	ed of	Bec	Ren Chen		,,							Zhuar	ng Me	ei Hong tural Route Number, City or Town, State, Zip Code)					
D 21215-0036 should be filed with 17 hours after death with the Maryland	and Mental Hygiene. 7 is marked other tl natic event, the Med	2	19a. Informant's Na	me/Relation	ship (Typ	oe, Print)			19b. Mailing	Address	(Street	and Numb	ber or Rui	ral Route N	lumber,	City or To	own, State	, Zip Co	ode)
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Baltimore, MD 21215-0036	Department or Important: I injury or oth	- [21. Signature of Fu	neral Service	/1		-			Name and A				ineral	L Ha	me,	D.C	200	
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	ician dical	2 Od	failure. List onl	y one cause	e on eac	h line.												Bet	ween Onset and Death
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Division tal or Attendi	after death Director: I in by the	icat	2 Accident	Inv	estigatio	28e Pt	9, 2008 ace of Inju		2242 hrs ne, farm, stre	eet, factory	, office b	uilding, et	tc.	28f. Location	on (Stree	et and Nu	mber or F	lural Ro	oute Number, City
Div	rs afte al Di	Certification:	3 Suicide 4 ✔ Homicide		uld not b termined	oe	y) Car						4	or Tow 105 Vista	n, State Way, F	ort Was	hington,	MD	
Hospi	24 hou Funer tely fil	S S	29a. Certifier	Certifying	Physicia	an: To the b	est of my	knowledge	, death occ	urred at the	e time, da	ate and pla	ace, and	due to the o	cause(s)	and mar	ner as sta	ated.	. (-)
o the	within 24 hours after death. To the Funeral Director: completely filled in by the	ledical	one) 2 🗸	Medical Ex	aminer:	On the basi and manne	s of exam r stated.	ination and	l/or investiga					the time, d					
1	ت ٦٩	ž	29b. Signature and	title of certi	fier	0 -	٨			290		e number			1		signed (M	onth, D	ay, rear)
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			Patricia Arc							a.0				J, 1710 2 1					
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Division of Vital Records. P.O. Box 68760 Fand

	DIVISION OF VITAL DECOLUS, F.O. DOA OOL OO,	
	To the Hospital or Attending Physician; The law requires that the death certificate be executed	Ph /I Ex
	within 24 hours after death.	y: Mo
	To the Funeral Director: After this certificate has been signed by the attending physician and	sic ed mi
1	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cia lica
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	-	For State Registrar	Certificate of Death	Reg. No.						
Physicia		1. Decedent's Name (First, Middle, Last) ALVIV L. CP		Date of Death Month Day 23	Year 3. Time of Death 15 0 9 PM					
/Medic Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death i3cLTimore					
Funeral Director		FRANKLIN SQUARE HOSPITAL CENT 5. Social Security Number 212608273 1 M 2 F 52	thday) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. /	Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) Maryland					
		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits					
ter death with the Marylan items 23a or 28a-f show incr must be notified at	to	MD Anne Arundel	Severn		1 □Yes 2 MÃ No					
ith the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of V						
s 23a	eral	8231 Tomlinson Court 11 Marital Status 12. Was Decedent Ever in U.S.	21144		d States e - American Indian,					
fter de r item inser	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rici	an, etc.) Blac	ck, White, etc.					
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hould nd Mer marke matic	ို	Frank Crosby, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b.	Gainey Doute Number, City or Town,	. State, Zip Code)						
alth ar 27 is er trau		1,121	231 Tomlinson Court Sev	vern, Marylan	d 21144					
es 1 a of He of item or othe		11 Burial 2 M Cremation 3 L Bemoval from State 1	of Disposition (Name of Date pry, crematory or other place)		- City or Town, State					
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permi Depa Impoi any ir		21. Signature of Funeral Service Licensee M0152 M0152	22. Name and Address of Facility Donaldson Funeral F 22 1411 Annapolis Road	Home & Cremat 1 Odenton, Ma	ory, P.A. ryland 21113					
		23a. Part. Enter the disease, or complications that caused the death. Do	not enter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death					
Physician		Immediate Cause (Final disease or condition resulting in death)	NG CANCER 05 EXPOSURE	-	Gridot and Boats					
/Medical Examiner		Due to (or as a consequence	05 EXPOSURE							
7 -	ner	Sequentially list conditions, if any, leading to immediate cause. First Underlying.	vij.							
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ertificat ing phy e as the	Physician/Medica	IF FEMALE:								
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iires that signed t	by P	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		ntribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown					
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he law e has l ige 2 s	Completed			autopsy performed?	prior to completion of cause of death? 1 □ Yes 2 □ No					
ian; T	a)	25. Was case referred to medical examiner?	26. Place of Death (7 163 2 2 100					
hysic this ce al direc	To 8	1 Yes 2 No Hospital: 1 Inpatient 2 ER/O		e 5 Residence 6 Ot						
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or Atten fer deat irector: n by the	Certification: T	2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	iarm, street, factory, office 28	f. Location (Street and Num City or Town, State)	ber or Rural Route Number,					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Ce	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place, an and/or investigation, in my opinion, death occurred	nd due to the cause(s) and r d at the time, date and place	manner as stated. e, and due to the cause(s)					
To the within 2 To the comple	Mec	29b. Signature and title of certifier A.	29c. License number 76	924	ed (Month, Day, Year)					
13		30. Name and address of person who completed cause of death (Item 23a O/2N ELINGSON MO, MOH, 910 31. Date filed (Month, Day, Year) Registrar's Signature	(Type, Print) 6 PH (N DEVH) A N. 2.	3240, No	21237					
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Loseles	- (•						
Registr		JUN 2 5 2008	Je y							

08-04741 Deor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 20520

on Coleman	1.	- For State	State	Oi Maryland	Certific	cate of l	Death	Wieria	11,9.0.	Reg. No	D.	20	00 200	
Physicia	_	egistrar 1. Decedent's Nan	ne (First, Middle,Las	st)					Mor	e of Death ith Day	, Ye		3. Time of Death 2302 hrs	
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	4	-	(if not institution, give	ve street and number	er)	4b	. City, Town, or I Cheverly	Location of De	eath		Prince (S	
			orge Hospital	ov 17	Age (In yrs. last b	oirthday)	If Under 1 Year	If Under 24	1Hrs. 8. Di	ate of Birth (M	M/DD/YYY	Y) 9. Birth	place (State or Foreign	
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Director	-	Usual Residence		X M 2 F		Yrs.		1_1						
any		10a. State	10b. County		10c. City, Tov	wn or Locatio	n						10d. Inside City Limits	
<u> </u>	-	DC Washington											1 XYes 2 No	
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of the alth and Mouth Briggiene. I man if them 27 is marked other than "natural", or other traumatic event, the Medical Examiner or other traumatic event, the Medical Examiner.		20a. Method of D	Disposition 2 Cremation	3 Removal from		ice of Dispos matory or oth	ition (Name of ce ner place)		Dat			•		
MOF Pages ent of mt: 14		_	5 Other Spec		Linco		orial Ceme	-	06/26/2	2008	Suitla	nd, Ma	ryland	
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. Boy he death v the att	15		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?			to the cause of death?	
P.O.	<u>م</u>									1 Yes 2 No 3 Probably 4 Unknown				
ords, P.O. w requires that the is been signed by is	Completed								- '	24a. Was at autops		4b. Were	autopsy findings availab completion of cause of	
COL law re has b	5	<u> </u>								perform	ned?	death?	?	
tal Rec sian: The l certificate b	ြိ		eferred to medical	1			26.Pla	ace of Death ((Check only				البيا	
Vital ysician: this certif director.	8	examiner?	r1	Hospital: 1	npatient 2	ER/Outpatier	nt 3 DOA	Other-4	Nursing H	ome 5 F	Residence	6Ott	ner:	
of Vital Records, ing Physician: The law require After this certificate has been si meral director, nase 2 should the	2	27 Manner of I		28a. Date	of Injury Day,Year)	28b. Time of	· · · -	njury at Work	Su	d. Describe h		ccurred		
On tendin eath.	į.	1 Natural	o i endi	igation Jun 19.	2008	FOUND: 2205 hrs	-	Yes 2 ✔	No	•			Rural Route Number, Ci	
Division tal or Attendi rs after death.	Certification:	3 Suicide	e 6 Could	not be 28e. Plac	e of Injury - At ho		eet, factory, offic	ce building, etc	c. 128	r. Location (S or Town, St Brandywine	ate)	Washino	iton. DC	
Division Division Hospital or Attend A hours after death Funeral Director:	ق	4 V Homici	deterr ide	ysician: To the bes	Local Stree		urrod at the time	date and nia						
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Furneral Director. After this certificancially filled in the the fineral director.	2	(Check only 1 one)	Certifying Phy Medical Exan	niner: On the basis	of examination ar	ge, death occ nd/or investig	ation, in my opir	nion, death oc	curred at th	e time, date a	and place,	and due to	the cause(s)	
To the To the To the	Medical	29b. Signature	and title of certifier	and mariner s	stated.			ense number					Month, Day, Year)	
		(h	100	Hall	au		0.	C.M.E.			June 2	0, 2008		
		30. Name and	address of person			23a)								
10		Carol Al	lan, MD Ass	istant Medical	Examiner	111 Penr	Street, Balt	imore, MD	21201					
	Stat		(Mor) (1741), 2°25	71111X 1 396	egistrar's Signati	KA	self 1							
Reg	ISIT	ill .		4		-	100000							

ORIGINAL

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Evaning must be notified at once.

Physician
) /Medical
Examiner

Baltimore, Maryland 21215-0036

4:40 а.ш.

JUNE 15, 2008

DONALD CURRIER

	Please Type or Print in	Black In	delible Ink. I	Ensure Al	Copies A	re Le	gible.					
	State of Maryla	nd / Dep	artment of He	alth and M	lental Hygi	ene						
	1 - State Registrar	Ce	rtificate of D	eath	Re	g. No.	2008	200	521			
	1. Decedent's Name (First, Middle, Last)				2. Date of Death _Month	_Dav	- Year	3. Time of De	diff			
n al	Donald S. Currier				Jüne 1	5 ^{Day}	2008	4:40	Дм			
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. Co	unty of Death					
	Stella Maris Hospice											
					Date of Birth (Month, Day,	Year)	9. Birthp Cour	lace (State or F etry)	oreign			
	214-16-8432 84	Yrs.			8-5-19	23_	MA					
	Usual Residence of Decedent 10a, State 10b, County 10c, C	itv. Town or Lo	ocation		10d. Inside City Limits							
0						1 XYes 2	□No					
rect	MD Baltimore Du 10e. Street and Number	ndalk	10f Zip Code		10	n Citizer	of What Cour	trv?				
٥			·				or what ood.	,.				
era	3417 Yardley Drive 11. Marital Status 12. Was Decedent Ever in U	IS 13		nanic Origin? (Sne			Bace - Americ	an Indian				
ᆵ	Armed Forces?		If Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)	1						
ρ		I	1 ☐ Yes 2X No	Specify:		Sp	ecify: Whi	te				
ted	15. Decedent's Education	16a. Dece										
e b b	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	e kind of work done dur DO NOT use retired)	ing most of workii	ng							
Ö	11	Sr	oecial En	gineer		Beth	lehem	Steel				
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)		18	8. Mother's Name	(First, Middle, M.	aiden Sui	rname)					
9	Irving Currier			Esther	Currie	r						
	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street and	d Number or Rura	al Route Number,	City or To	own, State, Zip	Code)				
	Robert Currier - Son	3401	l Loganvi	ew Dr.	, Dunda	lk,	MD 21	222				
	20a. Method of Disposition 20b.											
	I Buriai 2 Laternation 3 Removal from State			ry 6-18	3-08	Balt	imore	, MD				
	21. Signature of Funeral Service Licensee			of Facility					[omo			
	Distribution of the state of th	V .	213/						.ome			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Returned											
	Immediate Cause (Final	סשי				Onset and Death						
	resulting in death)											
	h control of the cont											
ner	Sequentially list conditions, if any, leading to immediate cause. Due to (or as a conse	Due to (or as a consequence of):										
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.											
	resulting in death) Last Due to (or as a conse	quence of):										
ca	d											
Completed by Physician/Medical	IF FEMALE:					1						
an/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregion to the past 12 months? 1 ☐ Live birth 2 ☐ Fe	tal death 3				230		-	ar			
Sic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)				mont.	Ju, 101				
Ę.		culting in the I	indertying cause given	in Part I	23e Did tob	acco use	contribute to t	ne cause of dea	th?			
Š	Tartification and an administration of the state of the s	suiting in the c	inderlying dadab given	iii citi.	1							
ed .					1	1						
d d					autopsy	,	prior to co	psy findings ava mpletion of cau	ailable se of			
် ပ					perform 1 □Yes 2	eg? X No	death? 1 ☐ Yes	2 □No				
Be	25. Was case referred to medical examiner?											
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cat	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury At				005 1 1 (0)			(D.) N. (
	determined 286. Place of Injury - At I	nome, farm, st <i>ify)</i>	reet, factory, office	'	281. Location (Str. City or Town,	eet and N State)	lumber or Hura	il Houte Numbe	r,			
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ca	(Check only 2 Medical Examiner: On the basis of examiner	nowledge, dea nation and/or i	m occurred at the time nvestigation, in my opir	, date and place, nion, death occurr	and due to the ca red at the time, da	tuse(s) ar ite and pl	iu manner as s ace, and due t	o the cause(s)				
Medical Certification: To	29b. Signature and hitle of certifier	11	29c. License r	number	29	d. Date s	aned (Month	Dav. Year)				
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Division of Vital Records, P.O. Box 68760, % To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 thours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2+\
State
Registrar

DR. ERNESTINE WRIGHT
31. Date filed (Month, Day, Year)

JUN 25

C 2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20522 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 24 2008 10:04 am June Richard Harrison Cannon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Center for Hospice Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 □ F 2/13/1932 Maryland Director 215-28-7164 76 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland_ Baltimore Middle River 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 21220 S. A. Funeral 9746 Conmar Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1957 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ XIO Specify. Specify: \$ 1987 er than "natural", 3 Widowed 4 Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, if a Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Military 12 Weapons Expert 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Anna Mae Fink ပ္ Richard Harrison Cannon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9746 Conmar Road Middle River, Maryland 21220 Bonnie B. Cannon (Wife) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 6/27 2008 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. Baltimore, Maryland 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 On Approximate Interval Between Onset and Death 23a. Can't 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ANOXIC ERAIN INJURY **Physician** DAYS /Medical Due to (or as a consequence of): **Examiner** METASTATIC LARYNICAL LANCER
Due to (or as a consequence of): MONTHS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed' 2 🗆 No 1 □Yes 2 DoNo 1 🗌 Yes Hospital or Attending Physician: this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To s after death.
I Director: After this
of in by the funeral d 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending investigation 1 □Yes 2 □No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital owithin 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

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annon

State Registrar

31. Date filed (Month Pay 2 Year) 2008

29b. Signature and title of certifier

N. MO 650 38 Registrar's Signature DANIEUE DOBERMAN,

29d. Date signed (Month, Day, Year) JUNE 24,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

BALTIMOREIMO 21204 6565 N CHARLES ST, SUITE 209

D64395

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician UNE 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HAMILTON BAL MO If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 ☐ M 2 🕅 F Months Days Hours Min. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it Medical Era in a river be multified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Quban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married ∠ ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☑ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TORRES 21050 20b. Place of Disposition (Name of cemetery, crematory or other cemetery) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 1 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tomule /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit PENTENSION Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Many er of Death 1 2 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes M 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier PHIGHAN D006455 s of person who completed cause of death (Item 23a) (Type, Print) vang Hest 821 my 31. Date filed (Month, Day, Year)
JUN 2 5 2008

DHMH 17 Rev 1/2001

State

Registrar

JUN 2 5

32. Registrar's Sig

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 140 P 2008 Hilda 20 ornish /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kiverview Rehabilitation and Health Center Baltimore Bultimore Maryland If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**K**F Months Days 220-22-0693 MARYLAND 80 7/1928 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.

ant: If item 27 Is marked other than "naturel", or items 23a or 28a-f show ary or other treumatic event, the Medical Examinat rought by notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 🕅 No Be Completed by Funeral Director BALTIMORE MARYLAND BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number .S.A. 14. Race - American Indian, 381 ENDSLEIGH AVENUE 21220 12. Was Decedent Ever in U.S. Amed Forces?
1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME CARE DOMESTIC 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ CATHERINE GRIFFIN WILLIAM PITTS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 381 Endsleigh AVe., Baltimore, Maryland 21220 Ernestine M Cornish-Fuller/DAu 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot 900.00. XX Burial 2 Cremation 3 Removal from State HOLLY HILLS MEMORIAL! 06-26-08 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 21. Signature Fy era Service Licenses 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 5 Other (specify) ☐ Yes 2 ☐ No 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06-20-2008 - M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUD. M-D - 21221. 709. WASERM. MALIKA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2008 3 2005 2015 2015 2015 2015 2015 2015 2015
	Physici		1. Decedent's Name (First, Middle, Last) BARBARA CHILCOAT 2. Date of Death Month June 21 2008 1:20p M
X	/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WHITE HALL BALTIMORE
Ĺ	Funeral Director		5. Social Security Number 6. Sex 122-26-7902 1 Months 2 Rs 3 Yrs. 83 Yrs. 6. Sex Months 2 Mon
	Maryland -f show fled at	tor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	th with the 23a or 28a ist be noti	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21161 USA
36	s after dear ", or Items :	by Funer	11. Marital Status 1
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed b	16a. Decedent's Usual Occupation (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry GROCERY STORE
ind 21,	be filed wit ntal Hygien d other tha event, the	Be	6 YRS CASHIER CASHIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Maryland	12 should be filed h and Mental Hygi Is marked other raumatic event, t	₽ P	GEORGE M. CORBIN MARGARET SHEELER 19a. Informant's Name/Relationship (Type. Print) LAWRENCE CHILCOAT(SON) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3002 ANDERSON RD. WHITE HALL, MD. 21161.
	Pages 1 and 3 nent of Health int: If Item 27 iry or other tr.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimore,	permit. Pages 1 a Department of Hee Important: If Item any injury or othe		4 □ Donation 5 □ Other (Specify) 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD. 21111.
68760,	Physician and physician and street prices it is physician and street prices it is physician and physician and physician and physician and physician and physician and physician are physician and physician and physician are physician and physician and physician are physician and physician are physician and physician and physician are physician and physician and physician are physician and physician and physician are physician are physician and physician are physician are physician and physician are physician and physician are physician are physician and physician are physician are physician and physician are physician and physician are physician are physician and physician are physician are physician are physician and physician are phys	al Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death of Cause (Final disease or condition resulting in death) Bue to (or as a consequence of): Due to (or as a consequence of):
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rds, P	quires that the de in signed by the a uld be detached i	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
I Reco		Completed	24a. Was an autopsy prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
n or	or Attending after death. Director: After in by the funer	Certification: To Be C	25. Was case referred to medical examiner? Yes 2 V
	the Hospital hin 24 hours of the Funeral upletely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To th within To th comp	Me	29b. Signature and altie operation 29c. License number 29d. Date signed (Month Day, Year) 29b. Signature and altie operation 29d. Date signed (Month Day, Year)
	4		30. Name and address dipplison who completed cause of death (Hem 23a) (Type, Print) ROBERT GATTUSO M.D. 16940 YORK RD. MONKTON, MD. 21111.
	Sta Registi	_	31. Date filed (Month, Day, Year) JUN 2 5 2008 33 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	ForState		irtment of Health and I rtificate of Death		ene g. No. 🤈 N	00000			
			Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	200	ar 3.4 mb of Death			
	Physicia /Medic		Elsie Trosky I	Downer		June 18,	2008	2:44 PM			
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	1	4c. County of I				
m 19			8754 Endless Ocean Way 5. Social Security Number 6. Sex 7. Age (In)	rs. last birthday)	Columbia If Under 1 Year If Under 24 Hrs.	8, Date of Birth	Howa:	, Birthplace (State or Foreign			
	Funeral Director		183-24-4467 ¹□м²⊠F 78		Months Days Hours Min.	(Month, Day, 12-29-	Year) 1929	Pennsylvania			
	and	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Loc	cation			10d. Inside City Limits			
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	r 28a	Director	10e. Street and Number		Columbia 10f. Zip Code	10	g. Citizen of Wha	at Country?			
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In Medical Evaniant must be notified anone.	by Funeral	11. Marital Status 1 □ Never Married 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	1	Nas Decedent of Hispanic Origin? (S f Ye's, specify Cuban, Mexican, Puerl I □Ye's 2000 Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. White			
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2121	filed within Hygiene. other than "	omp	Elementary/Secondary (0-12) College (1-4or 5+)	OFF		RATOR	FOO	D SERVICE			
פַ	be filed ntal Hyg ed other event,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, N					
Maryland	should b and Ment marked umatic e	다	MAKAR TROSKY		MAR		SNAK	1-4- 7'- C-4-1			
Nar	12 sho h and 7 is ma traum		19a. Informant's Name/Relationship (Type. Print)		ng Address <i>(Street and Number or R</i> Endless Ocean Wa						
	1 and 2 Health em 27 i		Donald G. Downer - spouse 20a. Method of Disposition		sition (Name of matory or other place)			ity or Town, State			
OL.	Pages nent of int: If its iry or o		1 Burial 24 Acremation 3 Hemoval from State		, 00	ine ., 2008	Catone	ville, MD			
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Sign or of Fugeral Service Consee M00053		2. Name and Address of Facility Ga						
m	permi Depar Impor any ir		Mark B. Bukaum	MM	p, Inc., 7250 was	sh. Blvd.	, Elkrid	ge, MD 21075			
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dying, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death			
in a	Physician		Immediate Cause (Final disease or condition resulting in death)	oral	nemore has	1e					
	/Medical Examiner	Due to (or as a consequence of):									
	7 -	ner	Sequentially list conditions,	sequence of j:							
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687	ificate g phys	edical	d				1	-			
P.O. Box	or Attending Physician: The law requires that the death certificate be executed inter death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date Mont				
ሚ ማ.	res that the de signed by the a be detached t	by Ph	Part II. Other significant conditions contributing to death but no	/) .		23e. Did tol		oute to the cause of death?			
ğ	w require s been sig should b	ed b	Dementia, atra	1 tilon	llation	1 □ Y∈	es 2 No 3	3 ☐ Probably 4 M Unknown			
Division of Vital Records,	The law re ate has be page 2 sho	Completed				24a. Was a autops perforr 1 🗆 Yes	sv pri	ere autopsy findings available ior to completion of cause of eath?			
/ita	ding Physician: The In. After this certificate hit funeral director, page	Be	25. Was case referred to medical examiner?		T	ath (Check only on	e)				
of \	Physic this c	.0		2 ER/Outpatie		Home 5 Reside	ence 6 Other				
no	ding I h. After funer	ţ	1 atural 5 Pending (Month, Day, Yea		Work? M 1 □ Yes 2 □ No	ZBG. Describe in	ow injury occurred	•			
Visi	Atten ar deat ector: by the	Certification: T	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (S	At home, farm, sti	reet, factory, office	28f. Location (Si City or Town	treet and Number n, State)	r or Rural Route Number,			
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	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Check only one) Check only 2 Medical Examiner: On the basis of examiner stated.	mination and/or ir	nvestigation, in my opinion, death occ	curred at the time, o	late and place, ar	nd due to the cause(s)			
	To the within To the comp	Me	29b. Signature and title of certifier	10	29c, License number	. ~	29d. Date signed	(Month, Day, Year)			
			30. Name and address of person who completed cause of death	(Item 23a) (Type	Print) V58 41	4 +	nove	401 2008			
	Ψ		Randal Riesett MO (3) 31. Date filed (Month, Day, Year) 32. Aegistrar's 3	Signature	Charter Driv	e Col	UMbig	MV 21044			
	Sta Regist		HILL OF COOL IN								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Пау Month Physician 06 19 2008 5:20a Doswell Dorothy Theodoria /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 12 Ogden Hall Ct Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 💥 🗆 F 05 01VA Director 62 227-60-3066 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Walton Evan, Inc. mat be notified at 1X Yes 2 □ No Director NA Baltimore MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. 21244 12 Ogden Hall Ct. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No Black Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Nursing Assistant Private Duty 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Cobbs Thomas Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12 Ogden Hall Ct., Baltimore, Md Doswell-Son Johnny 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Department | 1 Dep King Memorial Park 6/24/08 Woodlawn, 21. Signature Funeral Service Licens 22. Name and Address of Facility March F/H West 23a. Part 1. Enter the 18 sase, or complications that coused the death. shock, or heart failure. List only one cause on ach line. 21215 4300 Wabash Ave, Baltimore, Md the mode of dying, such as cardiac or respiratory arres Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine 00 attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year lor (Month Day 5 Other (specify) signed by the a ☐Yes 2 WNC Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been sirector, page 2 should Completed 245. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to nedical examiner? 26. Place of Death (Check on) Be Other: 4 \sum Nursing Home 5 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 1 Inpatient Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manne of D of Death 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29c. License number

29d. Date signed (Month Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 20529 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DANIELS 9:33 AM **Physician** June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 🗆 F NC 66 Director 239-66-1777 Usual Residence of Dec 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County show Yes 2 No Director Examiner must be notified MD Baltimore 28a-f NA 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ò items 23a 21213 U.S.A. 3748 Lyndale Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status and 2 should be filed within 72 hours after leath and Mental Hygiene. m 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo If Yes. Give Specify: Black þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education the Medical (Specify only highest grade completed) St. Francis Elementary/Secondary (0-12) College (1-4 or 5+) Academy Maintenance 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beatrice Johnson Ollie L. Daniels Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tran Willie Lee Daniels-Brother 8303 Lages Lane, Baltimore, 21244 Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 6/27/08 Woodlawn, Md Funeral Service Lice 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Maryland 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. SEPSI Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed burial-trar and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 | Fetal death 3 🗌 Ectopic pregnancy Year Month page 2 should be detached for in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes umphoc 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate has funeral director, page 2 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 \sum Residence Hospital: 2 ER/Outpatient 3 DOA 1 | Yes 2 | No 1 Inpatient 6 Other (Specify) မ 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No after death. filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only Medical within 24 hours to the total to the fune completely fi and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number . 29b. Signatule and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of pe

31. Date filed (Month, Day, Year)

JUN 2

5 2008

son who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

32

P45-000

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month :10A.M. **Physician** Gilda G. DeOms 2008 /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Glen Burnie Anne Arundel Baltimore Washington Medical Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Vear) Days 1 □ M 2 🛣 F Months Hours 84 02/09/1924 Emmitsburg, MD Director 218-12-210 3 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐Yes 2X No Parkville Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 8800 Old Harford Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Wagerman Roy Gelwicks ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 526 Koch Road Linthicum, MD 21090 Joan Mueller/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other parcens of Faith Cemetery 20c. Location - City or Town, State 20a Method of Disposition er place) 06/27/08 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rosedale, MD 4 Donation 5 Dother (Specify) Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service Linunsee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stlock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imica late Cause (Final mont **Physician** Nonworm disease or condition resulting in death) /Medical Due to (or as a consequence of) 2 Weeki Examiner var al ue o (or as a consequ Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 D No certificate I∐Yes 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier MD ss of person who completed cause of death (Item 23a) (Type, Print) Name and add m State Registrar

MARIA

Director

Funeral

Completed by

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Examine

Physician/Medical

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Certification:

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Physician /Medical

Examiner

Funeral Director

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5. Social Security N		PX 7. Age □ M 2 □ X	(In yrs. last birti	hday) If Und	der 1 Ye is Da		er 24 Hrs. Min.	8. Date	e of Birth nth, Day,	Year)		irthplace (Stat	e or Foreign
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	ied 2 Married	Armed Forces? 1 ☐ Yes 2 €	Го	If Yes, s	pecify (Cuban, Mexic	an, Puerto	Rićan, e	etc.)		Black, Wh	nite, etc.	
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Freddy (Canizalez/	Son	1	Biede	for	d C+	Darks	ri 1 1 a	s MΓ	21	23/		
20a. Method of Dis			20b. Place of	Disposition (A	lame o	f		Date				or Town, State	
	Sremation 3 ☐ S ☐ Other (Specify	Removal from State		y, crematory o				Jun					
21. Signature of Fu	ineral Service Licen	e Relly	01443	Crem	and Ad atio	ddress of Faci on and	ility Funer	al A	ltern	ativ	es	e, Mary	
23a. Part1. Enter t	he disease, or comp	olications that caused one cause on each lir	the death. Do n	ot enter the m	ode of	dying, such a	is cardiac	or respir	atory arre	st,	more,	Approxir Interval	d 21286
Immediate Cause disease or condition resulting in death)	(Final	a. memicillin			0(00	cur qu	itus	Bact	rtm) q	, Se	DSIS	Onset ar	
Sequentially list co	nditions,	b. Ostforny		The state of the s								-	
Cause (Disease or that initiated events	erlying injury	c. Infected	Infected heel ulter										
resulting in death)	Last	Due to (or as	a consequence o	f):									
IE EGNAL E	The state of the s									-			
IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ↓ 9 ☐ Unknown	pronths?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic 5 ☐ Other						23	d. Date of d Month	lelivery Day	Year
Part II. Other signi	ficant conditions o	ontributing to death bu	it not resulting in	the underlying	g cause	e given in Parl	i I.	236	e. Did tob 1 □ Ye		_	to the cause	of death?
								248	a. Was an autopsy perform	y ned3∕	prior to death'		gs available f cause of
25 Was case sets	red to medical									IZNo	1 □ Ye	es 2 No	
25. Was case refer examiner? 1 ☐ Yes 2/		Hospital:	26. Place of Death (Check only one) ospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Spe										1.5
27. Manner of Deat 1 Natural 2 Accident		28a. Ďate of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28d. Describe how injury occurred							ресіту)				
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injubulding, etc	ry - At home, far c. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				umber,	
29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination and	death occurred/or investigation	ed at th	ne time, date a my opinion, d	and place, eath occur	, and due rred at th	e to the ca	ause(s) a ate and p	nd manner place, and d	as stated. ue to the caus	e(s)

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate the completely filled in by the funeral director, pag

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Mentach For giron

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6000 JAMARITAN HUSPITAL OF BALTIMORE, 5601 Loch Raven Blvd., Baltimore, Mo. 21239

32 Registrar's Signature

MD.

DHMH 17 Rev 1/2001

29c. License number

Res 000

29d. Date signed (Month, Day, Year)

William Henry Edgerton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08-04103 2008 20533 UNK UNK Certificate of Death Reg. No. 1- For State 2. Date of Death Registrar Decedent's Name (First, Middle,Last) Month Day May 28, 2008 1725 hrs Physician/ Merica Examiner William Henry Edgerton 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Raltimore 1300 Block of Lemon Street If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Warren Co If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Hours Country)N.C. Months Days **Funeral** 4/14/1949 59 Yrs Director 244-84-3867 1X M 2 F 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b. County 1X Yes 2 No 10a. State Baltimore Maryland|Baltimore items 23a or 28a-f show ust be notified at once. 10g. Citizen of What Country? with the Maryland 10f. Zip Code 10e. Street and Number United States 21217 25 North Fulton Ave. 14. Race - American Indian, Black, Ճ 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 12. Was Decedent Ever in U.S. White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status Armed Forces? 'natural", or items Examiner must be 1 Never Married 2 Married Black Specify: 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year 3 X Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ð 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 he Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns injury or other traumatic event, the Matical Ex **Retail** Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dessie Moses

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Be Willie Edgerton 19a. Informant's Name/Relationship (Type, Print) 262 Red Hill Loop Rd. Warrenton, N.C. 27589

te of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Dessie Moses Edgerton / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Bunal 2 Cremation 3 X Removal from State Grove Cemetery 6/20/2008 Louisburg, 22. Name and Address of Facility Pope Funeral Homes, F Shady Grove Cemetery Donation 5 Other Specify 21. Signature of Funeral Service Livensee 5538 Marlboro Pike Forestville, Md. 20747 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and 23a. Part Enter the disease, or complications Physician Death failure. List only one cause on each line a. Pulmonary thromboembolism **ledical** Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) b. Deep vein thrombosis Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Teg injury
Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical X UNPENDED AMENDED PI line a-c,27,28a-f, perMF, g880 6/27/08 TT 23d. Date of delivery The law requires that the death certificate be 23c. If yes, outcome of pregnancy Box 68760, Year IF FFMALE: 3 Ectopic pregnancy 23b. Was decedent pregnant in the past 12 months? Fetal death Live birth Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown o þ of Vital Records, P. 24b. Were autopsy findings available 24a, Was an Completed prior to completion of cause of certificate has been a autopsy death? performed? 1 🗸 Yes ✓ Yes 2 No page 2 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, Other Nursing Home 5 Residence 6 Other: Be Hospital: examiner? Inpatient 2 🗸 ER/Outpatient 3 28d. Describe how injury occurred 1 Yes No 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Yeer 27. Manner of Death Certification: 1 Yes 2 injured leg 28f. Location (Street and Number or Rural Route Number, City 1 Natural Division Pending unk Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 Accident or Town, State) 6 X Could not be 3 Suicide determined (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 4 Homicide 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) and manner stated 29c. License number

State

29b. Signature and title of certifier

Jack Titus MD.

Deputy Chief Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 29, 2008

Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 🛭 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** <u>4:</u>57 ^{aм} Betty May Floyd 6/21/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospice of Chesapeake (Tate House) Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2K F 83 10/8/1924 Director 219-12-5531 Lanham, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the "hedical Examinal must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9240 Greenwood Lane Funeral U.S.A. 20716 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Completed by Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Liberty National Bank Bank Teller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Gundling ဥ Susie Elizabeth Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Floyd, Son 4025 Pearidge Rd., Bostic, NC 28018 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of i
Important: If ite
any Injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 6/24/2008 Alexandria, VA 4739 Baltimore Avenue 21. Signature of Funeral Service الله 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 2078: 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Cancer of Colon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 X No uneral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify)Hospice 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural death. filled in by the fu 1 ☐ Yes 2 ∏No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) uande D23743 June 23, 2008 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Martin Weltz, 7525 Greenway Ctr. Dr., Greenbelt, MD 20770 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOHN R. GRIFFITH /Medical 4a. Facility Name (It not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner mo 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**X**M 2□F 79 218 22 2737 05 Director 1928 Maryland Usual Residence of Decedent 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Sunset Circle 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 May Yes 2 No 1951 - If Yes, Give Year or Dates: 1953 1 Never Married 2 Married 1 ☐ Yes 2 No Specify s 1 and 2 should be filed within 72 hours a Health and Mental Hygiene. Completed by Specify: 3 Widowed 4 Divorced 1953 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Gas & Electric Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raight Savage Griffith ၉ Regina Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margherita Griffith - wife 7 Sunset Circle <u>Pasadena, MD</u> 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Department of 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State = 5 important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory: 6/21/08 Baltimore, MD 21. Signature of Emeral Service Licensee GJ Gonce Funeral Home, 21122 Riviera Dr. Pasadena, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DAYL SENJU /Medical Due to (or as a consequence of): Examiner 071EOWAE (1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and the death certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE use a 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Dav 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. as been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by MACHUTRITLON 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page perform certificate 2 1No Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ၉ 1 Yes 2 No 1 Inpatient Division or this 27. Manner eath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After Hospital or Attending 5 Pending investigation 1 atural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No n 24 hours after death.

le Funeral Director: A sletely filled in by the fu death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) JUN 2 5 2008 Registrar

AKID

COCIA MAVIJUSCUM BALTIMONIE 5601 mn 32. Registrar's Signature

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JUNE Rose Marie Geppi 22 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE HOSPIT n/a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🗹 F 75 213-28-9217 April 19, 1933 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examirar mast be notiffed at 1 ☐Yes 2 No Funeral Director Maryland Catonsville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21228 715 Maiden Choice Lane Apt. HV510 12. Was Decedent Ever in U.S. Armed Forces ↑ 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2 ▼No Maryland 21215-0036 Specify Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Department of Health and Mental Hygien important: if item 27 is marked other tha any Injury or other traumatic event. Item 2006. Administrative Office Manager Insurance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Julia Skirka Anthony Louis Geppi ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7113 Collingwood Court Elkridge, MD Lisa A. Upton / Niece Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Gds. 5/28/2008 Marriottsville, MD 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, MD 21. Signature of Funeral Service Licensee Made T- 2 21229 23a. Part 1. Enter the disea e. or omplic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER MICREATIC WEEKS 1ASTATIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dual to (or as a nonsixining of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): the attending physician hed for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Ye ar 5 Other (specify) P.0. 9 Unknown us cerrincate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð PERTENSION 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No Division of Vital e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 Suicide 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE

State Registrar 31. Date filed (Month, Day, Year) 2008 JUN 2 5

CE AS AR

32. Registrar's Signature

900 CATON AVENUE MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	1 - State of Maryland / Department of Health and M Certificate of Death		iene _{•g. No} 2008	20537
			1. Decedent's Name (First, Middle, Last)	2. Date of Deat	h	3. Time of Death
	Physicia		EVELYN GRAHAM	JUME	20 200	3 12:40 PM
	_/Medic	_	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	0 0.	4c. County of Dea	
1	Examin	er	FUTURE CARE OLD COURT. RAMPALLATOWN		BAL	TIMORE.
	Funeral		5 Social Security Number 6 Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign ountry)
	Funeral Director		212-30-7675 1 M 2 XF 76 Yrs. Months Days Hours Min.	02 28		MD
	ъ		Usual Residence of Decedent			10d. Inside City Limits
	how	.	10a. State 10b. County 10c. City, Town or Location			1 ☐ Yes 2 ☑ No
	e Ma	ᅙ	MD Baltimore Pikesville			
	ith th	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	ŕ
	ath w	ra .	8009 Mollye Road Apt C 21208	neitu Vac or No-	U.S.A	
	tems	nne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whi	
36	s afte	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ② No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates:		Specify: B1	ack
21215-0036	within 72 hours after death with the Maryland ene. Than "heturel", or Items 23a or 28a-1 show Ita Medical Examinat mast be notified at	ed t	15. Decedent's Education 16a Decedent's Usual Occupation		16b. Kind of Business	s/Industry
15	in 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ing		
212	with iene.	E	Elementary/Secondary (0-12) College (1-4or 5+) Nurse Nurse		Private	Duty
	Hygid other	Bec	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,	Maiden Sumame)	
a	should be and Mental Is marked o	ToB	Herbert A. Thomas Marie H			
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Ma	5	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Number	r, City or Town, State,	Zip Code) 21208
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "neturel; or Items 23a or 28a-1 show or other treumatic event, the Medical Examinat must be notified at		Michelle Thomas-Granddaughter 8009 Mollye Ros 20a. Method of Disposition (Name of Disposition (Name of Disposition)	ad, Apt	C, Pike	sville, Md
re	item			Date	20c. Location - City o	r Town, State
Ë	Pages nent of land: If its iry or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 6/2	28/08	Woodlawn	, Md
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: If item 27 li any injury or other tre		21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave	Pol+i	more. Md	21215
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate
			shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
	Physician /Medical		Immediate Gause (Final disease or condition resulting in death) a. Lunh (AncER) Due to (or as a consequence of):			
	Examiner		Due to (or as a consequence or).			
		e e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
V	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
· ·	exectan an an rial-tr	Еха	resulting in death) Last Due to (or as a consequence of):			
8760,	icate be executed physician and s the burial-transit	dical	d			
9	tifica ng ph as th	Medi	TEETINE.			٠.
Box	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of d	elivery Day Year
	requires that the death certific een signed by the attending p nould be detached for use as	Completed by Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown			
P.O.	that the de led by the a detached t	Phy	9 Unknown	23e Did to	phacco use contribute	to the cause of death?
Ś	es th igned	b	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.			Probably 4 known
ord	w requires that been signed b should be deta	ted	DIABETES MELLITUS			
Ö	aw as b	pje	HYPERTERSION	24a. Was autop	an 24b. Were a prior to death?	autopsy findings available completion of cause of
H	Th ate pag	S			2 No 1 □ Ye	s 2 No
/ita	Physician: Th this certificate ral director, pag	Be	ovaminar?	th (Check only o		
Ž	8 S F	2	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing H		dence 6 Other (Sp	pecify)
ב	ing P	on:	27. Manger of Death 1 Onatural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury 3 Nork? 1 Onatural 5 Pending (Month, Day Year) M M 28c. Injury at Work? 1 Yes 2 No	284. 00301001	low injury occurred	
sio	Attending r death. ector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be determined could not be determined.	28f. Location (5	Street and Number or	Rural Route Number,
Division of Vital Records,	or At	Certification;	4 Homicide determined building, etc. (Specify)	City or Tox		
	To the Hospitel or Attending Phy within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral to	S	29a. Certifier 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place	, and due to the	cause(s) and manner	as stated.
	24 hc 24 hc Fun etely	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	irred at the time,	date and place, and d	ue to the cause(s)
	To the within 2 To the comple	₩ W	29b. Signature and in a cycertifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
	- > F 0		D42723		June 23	RO 2009
•	1.		30. Name and address of serson who completed cause of death (Item 23a) (Type, Print) 5 UITE 303	. OL	D COURT	RAD
	6		AVVSABILALLI HARISH RANDALL	MOUN	his	21133.
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Regist	rar	JUN 2 5 2008 Mayor to Apriles			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Tanya Maria Griffin Month Physician /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner N/AGienera Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 214-86-6421 **Funeral** Year) 1 □ M 2√2 F Days Hours Min 36 28,1971Maryland Director Usual Residence of Decedent 10b. County Department of Health and Mental Hygiene. Industrial, or items 23a or 28a-f show amy injury or other traumatic event, the Medical Ever instruction is notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits N/A Maryland Director Baltimore 1 Yes 2 No 10f. Zip Code 21217 10e. Street and Number 10g. Citizen of What Country? 2140 Mt. Royal Terrace USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 ∑No 1 Never Married 2X Married Black If Yes, Give Year or Dates: 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) \$tate of Maryland Elementary/Secondary (0-12) Years Correctional Officer 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pamela Griffin Marshall Morton ပ္ 19b. Mailing Address (Street and Number or Bural Route Number City or Town, State Zip Code) 2140 Mt. Royal Terrace Baltimore, Mary 21217 19a. Informant's Name/Relationship (Type. Print) Pamela Griffin/ Mother 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 □ Burial 2 □ Cremation 3 Removal from State Woodlawn, Maryland King Memorial Park 6/28/08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Liga 23a. Part 1 Enter the dise Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause in each line Immediate Cause (Fin **Physician** monux disease or condition resulting in death) /Medical Jue to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician at the burial Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page After this certificate 2. No 1 ☐ Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2☑No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 TYes 2 Accident 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

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Was GRITHA Maryland 21215-0036

Baltimore,

Pages 1

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law requires that the death certificate be executed

The

or Attending Physician:

To the Hospital

Box 68760.

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Records,

Division of Vital

State

29b. Signature and title of certifier

1aya 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gudure

2 5 2008

0.90

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Day Year Physician Valerie Ann Gwinnutt 720 PM 2008 JUNE 20 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A HAZSUN 05 muzt 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months 1 □ M 2 X I F 54 Mary1and Director 217 64 6233 02/28/1954 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show Examiner must be notified at 1 ☐ Yes 2 € No Director Anne Arundel Glen Burnie Maryland with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21061 Items 23a 9 Gilmore Street U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any injury or other traumatic event the Man Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 28 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: þ 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Bus Driver School Bus Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Jenkins Nancy Quinton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Gilmore Street James Gwinnutt / Husband Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bavview Crematory Baltimore, Maryland 06/25/2008 4 Donation 5 Other (Specify) 21. Signal of Funeral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIAC **Physician** immediate /Medical Due to (or as a consequence of) Examiner MYOCANDIA Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or Examine or Attending Physician: The law requires that the death certificate be executed COZONANT burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death the a 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2 NO 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ပ 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death. To the Funeral Director: After this 27, Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 ☐ Homicide l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name

State Registrar ANDREW

2008

31. Date filed (Month, Day, Year) JUN 2 5

DHMH 17 Rev 1/2001

32/Registrar's Signature

3001 South Hanover St. Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Minn, e 2003 une 21 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Assisted Living Carroll Mt. orien Mt. Airy If Under 1 Year Junder 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2**V**F 217.14.3680 Yrs OCTOS477 1920 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No MN **Funeral Director** GLEN BURNIE DANE ARUNDEL 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21060 130AD 106 CARROLL 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore. Maryland 21215-0036 Specify: Completed by WHITE 3 Widowed 4 □ Divorced "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) CLERK ADMINISTRATIVE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental n and Mental MARKEL LOUIS BARBARA CAMTSIAH 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5883 WOODBINE ROAL WOODSING MD 21797 item 27 i FORREST HUDSAETH other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BOOK ICEMUT PRICES PELISTRY JUNE 25, 2008 HANDUCIS MARYLAND 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
ALATOMY WIFTS PAUS? RY 21. Signature of Funeral Service Licensee conscient drive, step hanourr, mb 200% 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arteru **Physician** evenare ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month Dav Year in the past 12 months? 5 Other (specify) ed by the detached o 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Arcile 1 ☐ Yes 2 ☐ No 3 ☐ Probably → COnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No. 24a. Was an autopsy performed? Yes 25 No page 2 s Jas certificate 1□ Yes or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be examiner? 1 ☐ Yes 2 ☐ Do Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTICATION Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Facility After t or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June Zi DDD59423 mo 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) #4150 Clarwolle, MD Break Circle 6030 Den Feinbe 20 3 Registrar's Signatur 31. Date filed (Month, Day, Year) JUN 2 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Herbert Leon Hayes icen 18 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Laurel HUSDITE Lawrel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 25 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**XM 2□ F Months Days Hours Min Yrs. 013-34-6081 63 Massachusetts 1945 Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9200 D. Gold Dust Court 20723 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □XYes 2 □ No If Yes, Give Year or Dates: 1XX Never Married 2 ☐ Married African 1 ∐Yes 2 🛣 No Specify. Completed by 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Howard County College (1-4or 5+) School Teacher 12th 5+ School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert S. Hayes Lucille Moody ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Hayes/Sister 7263 Montgomery Dr. San Antonio, TX 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 6/23/2008 Odenton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arterioseleutic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 INo 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 les 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner or Attending Physician: The law requires that the death certificate be executed after death. Box 68760, Division of Vital Records, P.O. To the Hospital within 24 hours a To the Funeral C completely filled Hospital

Director

r Items 23a or 28a-f show iner rount be notified at

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
The marked other than "natural", or Items 23 mir. If item 27 is marked other than "natural", or Items 23 mry or other traumatic event, the "wediest Experime rull".

permit. Pages 1 and 2 g Department of Health ar Important: If item 27 is any Injury or other trau once.

Physician

/Medical

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attending pl

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After this certificate

funeral director,

neral Director: /

29a. Certifier

(Check only one)

Baltimore, Maryland 21215-0036

the Maryland

with 1

Medical 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 3001 HOS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Hall James A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner wash 8814 Doris Drive If Under 1 Year | If Under 24 Mrs. 8. Date of Birth (Month, Day, Ye. 05/03/1949 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 6. Sex Social Security Number **Funeral** Days 1 M 2 □ F Months Alabama 59 418-88-7325 **Director** Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. Count item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Motical Examinat must be nutified at 1XiYes 2□No MD PG Ft. Washington Director 10f. Zip Code 10q. Citizen of What Country? 10e. Street and Number U.S.A. 20744 8814 Dorris Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates: ۾ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com grade completed) College (1-4or 5+) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) Disable 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othen any Injury or other traumatic event Be Genie Williams O'Bryant Hall, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8814 Doris Drive; Temple Hills, Maryland 20748 William O. Hall - Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/25/2008 Beltsville, Maryland Chesapeake Crematory 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Juneral Service Licens *lunda* 4594 Beech Road; Temple Hills, MD plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pne cause on each line. Approximate 23a. Part 1. Seter the disease, or conshock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ero **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the a ITYES 2 TNO 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 3 Probably 4 ☐ Unknown 2FTNo 1 ☐ Yes should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed 2 No 1 □Yes 2- No 1 ☐ Yes certificate 26. Place of Death (Check only one, Be 25. Was case referred to medical examiner? examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 24 hours after death. Funeral Director: After this letely filled in by the funeral dir 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide

within 2

State Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 2 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:29P^M 6/21 /2008 Phyllis Perico Humphries /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F Arkansas City, KS Yrs 83 /26/1925 515-16-3643 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location work itam 27 is markad other than "natural", or itams 23a or 28a-1 shov other traumatic avant, I'm Modical Examinal must be notified at 1⊠Yes 2 No Hyattsville Director MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20781 43rd Avenue, Apt. # 3 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White, etc. Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 Is markad othar than "natural", or Itar 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married American Indian 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Government Program Analyst 2 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ruth Boggs Harry Perico ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 130 S. Nettleton Ave., Bonner Springs, KS 66012 Jon Humphries, Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ita
any injury or ot 1 Rurial 2 Cremation 3 Removal from State 6/24/2008 Alexandria, VA *4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Avenu Hyattsville, MD 20781 Gasch's Funeral Home, P.A. TM Approximate Interval Between Onsetyand Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pheumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician ar Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, λq 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No has 1 Yes certificate or Attanding Physician: 26. Place of Death Check on one 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6/21/08 46052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sight Blik, MD 2001 Medical Panhway annapolis MD 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 5 200115-1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Funera	1	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr Hours Mir				lace (State or Foreign try)
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f Hear them other		20a. Method of Disposition		20b. F		sition (Name of natory or other place		Date		ation - City or To	wn, State
Pages ent o		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State		emorial Pa		25/2008	New C	astle.	Delaware
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N /		30. Name and address of person	who completed ca	ause of death (Ite							
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Funeral Director		5. Social Security Number 217–26–9801	6. Sex 1 □ M 2 🗶 F	7. Age (In yrs. la	Yrs.	Months Days	Hours Min.	(Month, Da 8/19/1	y, Year)	Cou	yland	
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r 28a-f show	Director	Maryland Balt 10e. Street and Number	imore	Ess	ex	10f. Zip Code			10g. Citize	en of What Cou	intry?	
3a or		317 Magnolia T	errace			21221			U.S	. A.		
ems S	Funeral	11. Marital Status	12. Was Dec Armed F		S. 13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14	 Race - Amer Black, White 		
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hours tural		15. Decedent		Dates.	16a. Deced	lent's Usual Occup	pation		16b. Kind	d of Business/I		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Evantinar must be notified at once.	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed	(1-4or 5+)	(Give life. L	kind of work done OO NOT use retire	during most of work d)	aing				
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be filk	Be	17. Father's Name (First, Middle,									llor	
hould d Mei marke	우	Norris Charle 19a. Informant's Name/Relationsl	S- N- H	Sr.	19b. Mailin	a Address (Street	Madelin t and Number or Ru			Friemi. Town, State, 2		
nd 2 si Ilth an 27 Is i rtraui		Dawn Christina		(Daughte						erstow		21136
s 1 ar of Hea item other		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other pla		Date		ation - City or		
Pages nent o int: If		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 【 X Other <i>(S</i> i	3 □ Removal from pec <i>ify)</i> Entom	n State			1 0/2	8	Balt	imore,	Maryla	ınd
ermit. Spartn Iporta Ny inju		21. Signature of Funeral Service	Licensee	•	B	. Name and Addre	ki Funera	1 Home	PA			
<u>205</u>		23a, Part 1. Enter the disease, or	Joffin	50	1	<u>407 Old :</u>	<u>Eastern A</u>	venue	<u>Essex</u>	, Mary	Approxima	te
		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.				or respiratory a	all est,		Interval Be Onset and	tween
Physician /Medical		disease or condition resulting in death)		o (or as a conseq		eumo	nice					
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ecuted and -transit	xaminer	Cause (Disease or injury that initiated events resulting in death) Last	C	o (or as a conseq	uence of):							
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ficate g phys	edic		d									
n certi	N/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pregnate birth 2 Feta		☐ Ectopic pregnan	ncv		2	3d. Date of de	-	Year
Attending Physician: The law requires that the death certificate be exerted add. ector: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the buria	Physician/Medical	in the past 12 months? 1 □ Yes 2 Ø No		egnant at time of		Other (specify)				Month	Day	Teal
at the d by the etach	Phy	9 Unknown Part II. Other significant condition	one contributing to	death but not res	ulting in the u	nderlying cause gi	iven in Part I.	23e. Did	tobacco us	se contribute to	the cause of	death?
ires the signe	þ		cer	douth but not 100	aning in the s			1 🗆	Yes 2]No 3∏P	robably 4 🖪	Unknown
v requ	etec	3						24a. Was	s an	24b. Were a	utopsy finding	s available
he lav e has	Completed							perf	opsy formed? 2 No	death?	completion of	cause of
an: T rtificat tor, pa	Be Co	25. Was case referred to medica	1				26. Place of Dea			12.10		
nyslci nis ce I direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2		nt 3 🗆 DOA		Home 5 ☐ Res			ecify)	
ing Pl	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	ng (M	te of Injury onth, Day, Year)	28b. Time of Injury	Wo	uryat ork? ⊒Yes 2 ⊒No	28d. Describe	how injury	y occurred		
ttend death stor: /	icati	2 Accident investi	not be	nce of Injury - At h	ome, farm, st	reet, factory, office				d Number or Fi	ural Route Nu	mber,
after Direc	Certification:	4 ☐ Homicide detern	nined bu	ilding, etc. (Speci	fy)			City or To	own, State))		
To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria		29a. Certifier 1 Certifyl	ng Physician: To	the best of my known	owledge, dea	th occurred at the	time, date and place opinion, death occ	e, and due to th	e cause(s)	and manner a	as stated. e to the cause	(s)
the Ho in 24 the Fu	edical	one)	and m	anner stated.						te signed (Mon		
Voir Con	Σ	29b. Signature and title of certific					6306		06	1241	2008	
,		30. Name and address of person	who completed -	ause of death (Ita	m 23a\ (Tuno	Print\				1071		
0		DR SAM AnTha	DR < 4 CC	9000	FRANI	KLIN SOI	ware c	R_ 13a	LTO	md	2123	7
Sta	te	31. Date filed (Month, Day, Year,	32	Registrar's Sign	ature	2000 1	eare c					
Registr	ar	JUN 2 5	ZUUS /	William 1	J. A.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Mai	yidild/	Certii	ficate of	Deatl	1	Re	g. No.	2008		
Physici: /Medic		1. Decedent's Name (First, Middle, L BOYD WILLIAM							Date of Death Month INE	Day	Year 2008	3. Time of D	M
, Examin		4a. Facility Name (If not institution, g	ive street and number)		41	b. City, Town, or	r Location	n of Death		4c. C	ounty of Death		
<i>, ,</i>		GILCREST HOSPIC 5. Social Security Number 6.	CE CENTER Sex 7. Age	(In yrs. last b	nirthday) li	BALTIM Under 1 Year		er 24 Hrs. 8.	Date of Birth	1	BALTIMOI	RE place (State or	Forei
Funeral Director		213-30-1294 Usual Residence of Decedent	1XXM 2□ F	74		onths Days	Hours	Min. Ma	(Month, Day,	Year) 193	Cour	H CAROL	
ryland ihow	_	10a. State 10b. County		10c. City, Tov	wn or Locati	on			-		1	0d. Inside City	
ne Mai 18a-fs	Director		IMORE CO			BALTIM	ORE		1 4/	On Citize	en of What Cour	1 ☐ Yes 2	-XX
with the		10e. Street and Number 3125 JEFFREY RO	NA D				244			0	.S.A.	iti y :	
death ms 23	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was	s Decedent of H es, specify Cuba		Origin? (Specify	Yes or No-		4. Race - Americ		
d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. Ith and Mental Hygiene and the standard	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2XXNo If Yes, Give Year or Dates:			es,specily Cuba Yes 2xi∑xNo	Specia		an, etc.)	s	Black, White, BL	ACK	
72 hou natura	Completed	15. Decedent's (Specify only highest g	Education trade completed)	16	Sa. Deceden	t's Usual Occup d of work done NOT use retired	ation during m	ost of working	- 1	16b. Kind	d of Business/Inc	dustry	
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should be ind Mental imarked o	P B	MORRIS HALL SE	₹.				E	EDELE BA	AILEY I	HALL			
2 sholl and [is ma	ľ	19a. Informant's Name/Relationship	(Type. Print)	19	9b. Mailing A	Address (Street	and Nun	nber or Rural R	oute Number,	City or	Town, State, Zip	Code)	
1 and Health sm 27 ther to	L	Alfreda Hall/Wif	e					Baltir			and 212		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exert in the cust be notified at once.		1 ☐ Burial 2XXCremation 3 4 ☐ Donation 5 ☐ Other (Spec	cify)	1	O CREM			06-26-0	08 1	BALT	IMORE, I	MARYLAN	<u>1D</u>
permit. Pages 1 an Department of Hea Important: If Item 2 any injury or other once.		21. Signature of Juneral Service Lic	ensee			LIAM C C W NOF			I YTINL	FUNE:	RAL HOM	E P.A.	
Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused t ly one cause on each line a. METAS	he death. Do 7477 C		the mode of dyli	non u ma		espiratory arre	est,		Approximate Interval Betw Onset and De	eath
ifficate be executed by g physician and stree burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		-								
The law requires that the death certifical ate has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at 9 Unknown	⊇ ☐ Fetal dea		ctopic pregnand	су			25	3d. Date of deliv	-	'ear
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The law require cate has been si page 2 should t	Completed by	STROKE							24a. Was a autops perforr	ned?	death?	ompletion of ca	wail ause
sician: The certificate rector, pag		25. Was case referred to medical					26. Pla	ace of Death (C	1 ☐ Yes : Check only on	/-	1 □Yes	2 LINO	
S S =	To Be	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpatier	nt 2 🗆 ER/0	Outpatient	3 □ DOA Oth	ner: 4 🗀	Nursing Home	5 🗌 Reside	ence 6	Other (Speci	ity) HOSAL	3
ng ffe		27. Manner of Death 1 ★ Natural 5 □ Pending 2 □ Accident investigat	28a. Date of Injury (Month, Day,	y 28b Year)	b. Time of Injury	28c. Inju Wor M 1	ryat rk?]Yes 2	_	f. Describe ho	ow injury	occurred		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, (<i>Sp</i> ec <i>ify</i>)	, farm, street	, factory, office		28f	Location (Si City or Town	treet and n, State)	d Number or Run	ral Route Numb	ber,
e Hospit 24 hour e Funera letely fille	Medical (29a. Certifier 1 Certifying 2 Medical Ex	Physician: To the best of taminer: On the basis of and manner state	examination	dge, death o and/or inve	occurred at the t stigation, in my	ime, date opinion,	e and place, and death occurred	d due to the d at the time, d	ause(s) late and	and manner as place, and due	stated. to the cause(s))
To the within 2 To the Comple	Me	30. Name and address of person when the street and stilled (Month, Day, Year)	Q)	r		29c. Licen:	se numbe	er 95	2	Ju	e signed (Month)	, Day, Year) 2008	
6		30. Name and address of person with DANIEUE DEFET	no completed cause of de	eath (Item 23a	a) (Type, Pri	nt) PLESSI	, su	UTE 209	BAL	TMI	RE, MO	21204	+
Sta Regist		, , , ,		r's Signature	Sec. 19	,							
negisti	2004	JUN 2 5 200	8 John Sular	So A	1000	-							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2:55 PM **Physician** QU /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner IMORE HARBORHOSPITAL BAL T N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🕱 F Maryland 63 01/26/1945 219 42 1594 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County a or 28a-f show t be notified at 1 X Yes 2 No N/A Baltimore Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with U.S.A. 21225 "natural", or items 23a 4122 Audrey Avenue Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 in and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Gate Petroleum Auditor 11th traumatic event, 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert W. Mullen Betty I. Toshok 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health ar Important: If Item 27 Is any Injury or other trau 2418 Lotus Road East Jacksonville, Florida 32211 Robert Vest / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 06/21/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Bayview Crematory 21. Signatur Fun ral Service Licen 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HRO OBSTRUCTIVE Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit and Due to (or as a consequence of) Box 68760. ttending physician or use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown ate has been signed by page 2 should be detach 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

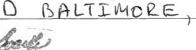
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ٥ RES-001 JUNE, 18,2008 an 3001 SOUTH HANDVER STREET BALTIMORE, MD 21225

State Registrar

31. Date filed (Month, Day, Year) JUN 2 5 2008





MO

08-04028 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Lewis Hicks State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 26, 2008 1547 hrs Medical Examiner John Lewis Hicks 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Parkville **Baltimore County** 2941 Manns Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Hours Davs Director unk unk unk Country) unk 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c, City, Town or Location 1 Yes 2 No or 28a-f show Baltimore Parkville Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2941 Manns Avenue 21234 .S.A. Funeral 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Specify: White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: þ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 'ages 1 and 2 should be filed within 72 h
ant of Health and Mental Hygiene.
nt: If item 27 is marked other than "r
other traumatic event, the Medical E Baltimore, MD 21215-0036 Carpenter Residential 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Mary Evelyn Evans Elmo Jackson Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ron Hicks, Sr./brother Parkville, MD Manns Ave.. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If i crematory or other place) Burial 2 Cremation 3 Removal from State Chesapeake Crem. 06.06.08 Beltsville, MD Donation 5 Other Specify è 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Balto., MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED 23a,27,perME,9880 6/27/08 TI attending physician or use as the burial Records, P.O. Box 68760, The law requires that the death certificate be 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? 1 🗸 Yes ✓ Yes 2 No the Hospital or Attending Physician: Ihin 24 hours after death. the Funeral Director: After this certifi upletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 V Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 _ 6 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within To the 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 27, 2008 30. Name and address of person who completed cause of death (Item 23a) Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 David Fowler M.D.

State Registra

31. Date filed (Month, Day, Year)

ORIGINAL

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:00 AM June 17 2008 /Medical Esther Hernandez 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Towson If I Inder 24 Hrs. Baltimore

9. Birthplace (State or Foreign Country) Gilchrist Center for Hospice Care If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🔀 F Director 84 Spain 02/09/1924 213-54-8556 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Indepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Experiment must be recified at once. 1 ☐ Yes 2 2 40 Director Hyattsville MD Prince Georges 10g. Citizen of What Country? 10e. Street and Number 1836 Metzorott Road Apt. 609

1. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? 20783 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □Yes ZNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1. Yes 2 No δ 3 Widowed 4 □ Divorced Hispanic Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Domestics Elementary/Secondary (0-12) College (1-4or 5+) House Keeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (ပ <u>Unknown Unknown</u> Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2711 Curry Dr. Hyattsville, MD 20783 Maria Morataya/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jun 21 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland Chesapeake Crematory
22. Name and Address of Facility 2008 21. Signature of Funeral Service Licensee M01443 Cremation and Funeral Alternatives) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TROKE **Physician** /Medical Due to (or as a consequence of): RONARD Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine sician and Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

n 24 hours after death.

le Funeral Director: A pletely filled in by the fu within 2 To the I

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBERMAN, MD DANIEUR 3. Registrar's Signature 31. Date filed (Month, Day, Year) State

6565 N CHARLES ST, SUITE 209 03462

Registrar

29a, Certifier

29b. Signature and title of certification

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D64395

29d. Date signed (Month, Day, Year)

JUNE 17, 2008

BALTIMORE, MA Z1204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 20551 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 0333 A.M **Physician** 06 21 2008 /Medical SANTOS INTERIANO - ARBUETA 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE, MO UNIV. OF MARYLAND NEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
111 Salvador 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Year) 1,1984 123 M 2□ F 23 Months Days Hours October None Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantual crust be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 INo Director Maryland Howard County Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3125 Wheaton Way Apt. B 21043 El Salvador Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married altimore, Maryland 21215-0036 1\Yes 2□No Specify:Salvadorian Specify: Salvadorian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/ /\ Farming Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesus Interiano Gregoria Arqueta ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (U.S.A.) 19a. Informant's Name/Relationship (Type. Print) Mr. Aquileo Argueta (Friend) 3125 Wheaton Way Ellicott City, MD. 21043 Apt. B _20c. Location - City or Town, State El Carmen, El Salvador, unk. Date 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition H Burial 2 ☐ Cremation 3 ☐ Removal from State El Carmen Cemetery Central America 4 ☐ Donation 5 ☐ Other (Specify) Peaceful Alternatives Funeral&Cremation Ctr.P.A. 2325 York Road Timonium, Maryland 21093(U.S.A.) 21. Signature of Funeral Service Licenses 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ISCHEMIC CHS disease or condition resulting in death) INJU RY /Medical Due to (or as a consequence of): Examiner MULTI-OPGAN DYSPUNCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusito (or as a consequence of) sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) e has been signed by the ge 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ★No 24a. Was an certificate 2 □ No 1 Yes Division of Vital the funeral director, p Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27 No 1 🔲 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 6/21/08 G16001 N.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALISA GIBSON M. D 22 S. GREGENE ST., BALTIMORE, MD 2120 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3:40 pml 21 2008 June Jagernauth 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Rossville Manor Care Health Services 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1 □ M 2 💢 F 1/29/1937 Guvana 215-33-6922 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 1 ☐ Yes 2 XNo Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 Guyana 1503 Nicolay Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🎇 No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jagernauth Budhai ို Goolsaren Chowlen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Essex, Maryland 21221 1503 Nicolay Way Doodnauth Jagernauth (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 6/24 2008 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland Bayview Crematory ^{22.} Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licensee PA Essex, Maryland 21221 ccial 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sep 515 r as a consequence of) angene Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 21 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Injury Natural 1 🗌 Yes 2 🗌 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mind in once.

be executed attending physician and for use as the burial-transit Division or Vital Records, this certificate funeral director, To the Hospital or Attending Provithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

Box 68760,

P.O.

Examiner Physician/Medical þ Completed Be P Certification:

Medical

State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Signature and title of certifier		
mularan	1/4	1
	·M	/)

29c. License number

29d. Date signed (Month, Day, Year)

पेठ गा

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) balows a Rd 0 1842

nardon 31. Date filed (Month. Day.

4 Homicide

29a. Certifier

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** nne /Medical 4a. Facility Name (If not institution, give street and n 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore HOSPIta. Preral 8. Date of Birth (Month, Day, Year) 5 -3 - 1948 (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1**M** 2□ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 es 2 No Director more 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Sector dary (0-12) College (1-4or 5+) raine ce 18. Mother's Name (First, Middle, Maiden Surnai 17. Father's Name (First, Middle, Last) Be 7. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) assandra Ster) 1602 Che 2

20b. Place of Disposition (Name of cemetery, crematory or other place - Welch esaco Zoseda 20a. Method of Disposition Important: If it any Injury or c Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, 23a, Part1 Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a cons. 1) nce of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner phalo pathy death certificate be executed burial-transit and physician Physician/Medical the as for use a IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) ed by the a detached f 9 Unknown م been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 2 No or Vital Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Nocem 2008 matun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore IMD alalt 501 hhin A MATUN NAFEM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 2 5 2008

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 2055
	Physici		Decedent's Name (First, Middle, Last) NELLIE MYRTLE KOEHLER 2. Date of Death Month Day Year JUNE 23 2008 6:40P M
-	/Medio		a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death TOWSON 4c. County of Death BALTIMORE
	Funeral Director		Social Security Number 6. Sex 1317 7. Age (In yrs. last birthday) 1 M 20XF 85 7. Age (In yrs. last birthday) 1 Months Days Hours Min. Nonths Days Hours Min. 1 Under 1 Year If Under 1 Year If Under 24 Hrs. 1 Months Days Hours Min. 1 Under 3, 1923 9. Birthplace (State or Foreign Country) Maryland
Baltimore, Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	Job
Baltimore, Mar	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked othe any Injury or other traumatic event, once.		19a. Informant's Name/Relationship (Type. Print) John K. Koehler, Jr. (Son) 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1318 Spring Avenue Baltimore, Md. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Mem. Pk. Cem. 6~27~2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Signature of Funeral Service Licensee 24. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Sann Funeral Home 27. Address of Facility 27. Name and Address of Facility 28. Signature of Funeral Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Date 10 Date 10 Date 10 Date 11 Date 12 Date 12 Date 13 Date 14 Donation - City or Town, State 14 Donation - City or Town, State 15 Date 16 Date 17 Date 18 Date 18 Date 19 Date 19 Date 19 Date 10 Da
8760,	Physician /Medical Examiner physician and physician and sthe purial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Due to (or as a consequence of):
Vital Records, P.O. Box 6	e law requires that the death certii has been signed by the attending je 2 should be detached for use a	Completed by Physician/Medical	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Month Day Year 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Month Day Year 23d. Date of delivery Month Day Year 24d. Was an autopsy Day Probably Day Pro
Division or Vital	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Medical Certification: To Be Co	25. Was case referred to medical examiner? 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) JUN 2 5 2008 Registrar's Signature

6:40 P.M.

2008

JUNE 23,

NELLIE KOEHLER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** -1e /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 □ F Yrs. **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 No by Funeral Director Baltimore arkuil 10g. Citizen of What Country? 10e. Street and Number Hvenue 12. Was Decedent Ever in U.S. Armed Forces?

1 DYes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any injury or other traumatic event. If the sonce. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 ⊠No 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>xthlehem</u> 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) emeter 22. Name and Address of Facility Evans, Funeral Chape 8800 Harford Rd 21. Signature of Funeral Service Licensee Services Parkville +Cremation pel 21234 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) Ö 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>^</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the contr (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier eted cause of death (Item 23a) (Type, Print) 30. Name and address of pe

State Registrar

31. Date filed (Month, Day,

JUN 2 5 2008

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia
/Medica
Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liury or other traumatic event, the Medical Evarinar must be notified at any liury or other traumatic event, the Medical Evarinar must be notified at any liury or other traumatic and any liury or other traumatic event, the Medical Evarinar must be notified at any liury or other traumatic and any liury or other traumatic and any liury or other traumatic and line and l

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,<

	•	1 - State Registrar		Cert	ificate of I	Death	Reg. N	<u> 2008</u>	20556
		1. Decedent's Name (First, Middle, Last)	2				2. Date of Death Month Da	ay Year	3. Time of Death
Physicia Medic/		Unseph F. K	enne	dy			June 23	2008	9:30 AM
Examin		4a. Facility Name (If not institution, give street and number	er)	1	4b. City, Town, or	Location of Death	40	c. County of Death	1
		2903 Hiss Avenue	2		Par			Balt	imore
uneral		5. Social Security Number 6. Sex 7.	Age (In yrs. last bi	i iii uuy / 🛌	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year	9. Birth	hplace (State or Foreign untry)
irector		212-28-0855 1×M 20F	77	Yrs.	Wioriting Days	1 1	April 21,19		injland
		Usual Residence of Decedent							10d Incide City Limits
how 1		10a. State 10b. County	10c. City, Tow	n or Loca	tion				10d. Inside City Limits
a-fa	양	mb Baltimore	-	ar	Kuille	2			1 ☐ Yes 2.☑ No
or 28)ire	10e. Street and Number			10f. Zip Code	- 1	10g. C	itizen of What Co	untry?
23a	<u>a</u>	2903 Hiss Flyenu	e		212	34		USA	
S E	Funeral Director	11. Marital Status 12. Was Decede Armed Force	nt Ever in U.S.	13. Wa	as Decedent of H	lispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No-	14. Race - Amer Black, White	
a E		1 Never Married 2 Amarried 1 Aves 2			os, spoony out	Specify:	,,	Specify:	, 0.0.
E d'.	d by	3 ☐ Widowed 4 ☐ Divorced Year or Date	s:					W	hite
dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a	(Give ki	nt's Usual Occup nd of work done	during most of workin	g 16b.	Kind of Business/I	ndustry
lan.	du	Elementary/Secondary (0-12) College (1-40	or 5+)	life. DO	NOT use retired	d) -			
t, the	S	8		FI	inter			100 Gr	avore
doth	Be	17. Father's Name (First, Middle, Last)	1			18. Mother's Name	(First, Middle, Maide	n Surname)	1
arke	၉	Walter Francis	Kenne	dy		Mar	trance	5 Do	yle
is m		19a. Informant's Name/Relationship (Type. Print)	19	b. Mailing	Address (Street	and Number or Rura			
n 27 ier tr		Bernadette Kennedy-	wite 2	100				MD 2	
i ter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	comete	of Disposit ery, crema	ion (Name of tory or other plac		ate 20c.	Location - City or	Fown, State
ant: I		4 □ Donation 5 □ Other (Specify)	Packy	Doed	Cemet	ss of Facility	-08 Bc	altimor	e, mb
Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evandar must be notified at once.		21. Signature of Funeral Service Licensee	(22.	Name and Addre	ss of Facility	1+000000		
8 = 8		Havi & Ma	utu	88	on Hace	ford Rd	Parkville	mD 21	ces-Parkville 234
		23a. Part 1. Enter the disease, or complications that cau	sed the death. Do						Approximate Interval Between
sician		shock, or heart failure. List only one cause on each Immediate Cause (Final	n line.	- 0	7 3	Disease	,		Onset and Death
edical		disease or condition resulting in death)	as a consequence	-	2	DISEASE			Syears
miner		But to (or	as a concoquento	0.,,.					
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or	as a consequence	of):					
d ansit	Ē	cause. Enter Underlying Cause (Disease or injury that initiated events							
n an ial-tra	Examiner		as a consequence	of):					
nding physician and use as the burial-transit	ca								
g phy	/Medical								
ndin use a	M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco						23d. Date of del	livery
atte I for	cia	in the nact 12 months?	th 2□Fetal deat nt at time of death		Ectopic pregnand Other <i>(specify)</i> _	;y		Month	Day Year
y the	Physicia	9 Unknown 9 Unknow	/n						
deta		Part II. Other significant conditions contributing to deat	h but not resulting	in the und	erlying cause giv	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
n sign	d by	Coronary Artery	Diseas	e			1 Tes	2 🗖 No 3 🗆 Pr	robably 4 🗆 Unknown
peel	Completed	Hypertension					24a. Was an	24b. Were au	utopsy findings available
has ge 2	ш						autopsy performed?	prior to death?	completion of cause of
ficate r, pag		Hypercholesterol	emia				1 ☐ Yes 2 🗷 N	lo 1 ☐ Yes	2 □No
certif	Be	25. Was case referred to medical examiner? Hospital:			all pos Oth	26. Place of Death			
al di	£.	1 ☐ Yes 2 ☑ No ☐ 1 ☐ Inp 27. Manner of Death	atient 2 ER/C	Time of	3 LI DUA	4 LI Nursing Hor	ne 5 M Residence 8d. Describe how in		cify)
After	io	1 Matural 5 ☐ Pending (Month,	Day, Year)	Injury	28c. Inju Wor M 1		.au. Describe now inj	ary occurred	
the the	cat	2 Accident investigation 3 Suicide 6 Could not be	Injury At home f	orm otro			8f. Location (Street	and Number or Pr	ural Pouta Number
Direc in by	Certification: T	determined 200.1 lace of	Injury - At home, f , etc. <i>(Specify)</i>	aiii, siice	st, lactory, office		City or Town, Sta	and Number of The	nar riodle Wariber,
filled		29a. Certifier 1 **Certifying Physician: To the bo	net of my knowledge	no death	negured at the ti	me date and place	and due to the cause	(s) and manner of	s stated
To the Funeral Director. After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Medical	(Check only 2 Medical Examiner: On the bas	is of examination a						
the mple	Med	one) and manne 29b_Signature and title of certifier	Jaiou.		29c. Licens	se number	29d F	Date signed (Mont	h, Day, Year)
₽8	_	00-	5	~		11 11 -0	,	12.1	7660
		77		-	10.00	46458		0/23/0	KUDS
5		30. Name and address of person who completed cause	of death (Item 23a) (Type, P	r 1	01 2	14.	a mr	7+73/
		31. Date filed (Month, Day, Year)	jistrar's Signature	170	artord	nd IJ	alhmor	e 11113	41657
Sta Registr		JUN 2 5 2008		Some					
-		AGIL VI O FAAA LAGOOM		-					

Division or Vital Records, P.O. Box 68760,		Baltimore, Maryland 21215-0036		
Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.	Phy /M Exa	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Denatment of Health and Mental Hucitane.	F D	
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit	sicia edica imine	inportant: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	uner irect	Exar

		For State Of Ma	Ce		of Dea			Reg. No		08	2055	
iciar		1. Decedent's Name (First, Middle, Last) Helen M.	V 1				2. Date of De Month		ay 20	Year 08	3. Time of Death 7:30 P.	4
dica nine		4a. Facility Name (If not institution, give street and number)	кучат	4b. City, T	own, or Local	tion of Death	June		c. County o		7.50 1.	-
lerant.		Mariner Health of North Ar	unde1		Glen Bu				Anne	Aru	ndel	
al or		213 30 5843 1□M 2X□F	e (In yrs. last birthday) 101 Yrs.	If Under Months	1 Year If Ur Days Hou	nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da 09/26/1	ay, Year)	9. Birth Czec	olace (State or Foreigntry) Choslovaki	ın .a
	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation						1	10d. Inside City Limit	s
į	5	Maryland Anne Arundel	Baltimo	ore							1 □Yes 2X□N	D
2		10e, Street and Number		10f. Zip (_		-	itizen of WI		ntry?	
Europea Dispostor	200	5414 Wasena Avenue 11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decede	21225 ent of Hispania		ecify Yes or No		U.S.A		can Indian,	
100	- ka	Armed Forces? 1 ★ Never Married 2 Married 1	No	If Yes, speci	_	xican, Puerto	ecify Yes or No Rican, etc.)	,-		White,		
Completed by	200	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual	Occupation k done during e retired)	most of work	ina	16b. H	Kind of Bus	iness/In	dustry	
100	+	Elementary/Secondary (0-12) College (1-4or 5)+)	<i>Do Not use</i> Careta		most of work	n rg		Self-	omn ¹	Loved	
3	9	12 U11 17. Father's Name (First, Middle, Last)		oai e ca		/lother's Name	e (First, Middle				Loyeu	_
a of		Louis Hajo	ovsky			Jul:	ia Este	rila	ì			
ľ		19a. Informant's Name/Relationship (Type. Print)					al Route Numb					-
	-	Donald Barnett / Nephew 20a. Method of Disposition			Point		8 Ea		, Min		ota 55123	
		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disponsion Cemetery, cres				7/2008			,	Maryland	
once.	-	21. Signaturo 1 Funera Behince Licensee	22	2. Name and	Address of F	acility Go	nce Fun	era]	L Serv	rice	, P.A.	_
	1	23a. Part1. Enter the 1999 r complications that caused	the death. Do not ent		itchie		-		ore, r	dary	land 21225 Approximate)
		shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition	Micoel	Don	nout	ia					Interval Between Onset and Death	2
d ²		resulting in death)	a consequence of):	4500	0					-	Potter John	
,		Sequentially list conditions, b. Due to (or as	a consequence of):								*****	
- in		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of.									
FYS			a consequence of):									_
edical Evaminer		d										
		IF FEMALE: 23c. If yes, outcome	pf pregnancy						02d Data	of dollar		_
Completed by Physician/M	,		2 Fetal death 3	Ectopic pre Other <i>(spe</i>					23d. Date Mont		ery Day Year	
) o		Part II. Other significant conditions contributing to death be	ut not resulting in the u	nderlying ca	use given in P	Part I.	23e. Did t	obacco	use contrib	oute to t	he cause of death?	
Pod		Bysphafia hype	stensi De	, d	abres	5184	1 🗆	Yes 2	2□ No 3	Prol	pably 4 Conknow	n
aluu							24a. Was autoj	psv	24b. W	ere auto	opsy findings availabl Impletion of cause of	е
Ö		OF Was against to madical					1∐ Yes	2 N		ath? ☐Yes	2□ No	
To Be		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatier	nt 3□ DO		-	h <i>(Check only c</i> me 5 □ Resi		6 □Othor	(Special	5 ₍₁₎	_
1		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day	ry 28b. Time o		c. Injury at Work?		28d. Describe				<i>y</i> /	_
Catio		2 Accident investigation		M	1 Yes		20f Location /	Ctro at a	and Alexandra	. o. D	al Route Number,	
Medical Certification:			ury - At home, farm, str c. (Specify)				City or To	wn, Stat	'e)		· · · · · · · · · · · · · · · · · · ·	
dical		29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner sta	examination and/or in	n occurred a vestigation,	t the time, dat in my opinion	te and place, , death occur	and due to the red at the time,	cause(s date ar	s) and man nd place, ar	ner as s nd due t	stated. o the cause(s)	
Me	-			29c.	License numb	ber		29d. Da	ate signed	(Month,	Day, Year)	_
		Afterding Phys	acian		D 000	7787	3	0	6/33	12	008	
		29b. Signature and title of certifier the week of the house of the hou	eath (Item 23a) (Type,	Print)	PITAL	. DPI	VE, GL	4D	30	RNI	E, Md,	
tate		31. Date filed (Month, Day, Year)	ar's Signature									

08-04791

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3ernard	Joseph	Kepler
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2	0	0	8	20	5	5	3
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			For State Certificate of Death							Reg. No. 2. Date of Death 3. Time of Death						
	Physicia		1. Decedent's Name (First, Midd	le,Last)	2							Year		e of Death		
1	ા Examir		Bernard Joseph Kepler							Month June 21,	34 hrs					
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death								4c. C	County of D	eath			
		н	Johns Hopkins Bayvi	ew Medical Cer	iter		Baltimore									
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	est birthday)	If Under 1 Ye		r 24Hrs.	8. Date of B	,	F	: Birthplace oreign	(State or		
	Director	1	219-84-9709	1 M 2 F	35	Yrs.	Months Da	ys Hours	Min.	05-1	5-19	73	Country)	MD		
		ŀ	Usual Residence of Decedent		L											
	any	-	10a. State 10b. County 10c. City, Town or Location											nside City Limits		
	≱ .∗ı		MD Balt	imore									1 _	Yes 2 No		
	rylan 8-f sl	용	10e. Street and Number				10f. Zip Code				10g. Citize	Country?				
	th the Maryland 23a or 28a-f sho	Director	7210 Dunwood Ct.					21222 U.					S.A.			
	ith th						s Decedent of H	Ispanic Orie	gin? (Spe							
	ath w	Funeral	1 Never Married 2	Married Armed F	orces?		es, specify Cuba					White, e	tc.			
	er de		3 Widowed 4 Di	vorced If Yes, Give Ye	2. No	1	Yes 2 N	o specify:			s	Specify:	Whit	e		
	rs aft	3	15. Decedent's Education (Sp	or Dates:			t's Usual Occup			ork done	16b. Kii	nd of Busin	ess/Industr	y		
	2 hou	Completed	Elementary/Secondary (0-12		(1-4 or 5+)	during m	ost of working lif	e. DO NOT	use retire	ed)						
	hin 72 than than edical	힐	9			Labore	er			Construction						
	d with	탉	17. Father's Name (First, Middle	e, Last)		L			Nother's Name (First, Middle, Maiden Surname)					4		
	e file al Hy ced o	Be	Samuel Reid					Debo	orah	ah Rosenthal						
	Dre, MD 21215-0036 es I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-fish her traumatic event, the Medical Extensions.	10	19a, Informant's Name/Relation	ship (Type, Print)		19b. Mailing	g Address (Str	eet and Nur	nber or Ri	ural Route N	umber, City	y or Town,	State, Zip C	ode)		
	MD id 2 sho lith and m 27 is		Deborah Rose	enthal/M	other	463	Peregi	ne St	t. V	irgin	ia E	Beach	ı, VA	, 23462 State		
	and and frealth		20a. Method of Disposition		20b.			emetery,	Tun	e ^{Date} 24,						
	nore, MD 21215-0036 ages 1 and 2 should be filed within 72 at of Health and Mental Hygiene. t: If item 27 is marked other than ' other traumatic event, the Medical		1 Burial 2 Crematic			crematory or ot	ake Cr	em.	200	8	Be1	ltsvi	11e,	MD		
	F 2 6 7	-	4 Donation 5 Other \$ 27 Signature of Funeral Service				Name and Addre					- D	Tab			
	Balti permit. Departir Imports injury o		27. Signature of Publical Service	Q T	61443		17 Gre		CA	FA/SE	epne	≘n ມ. ໄລ 1 + i	. MD	rmann P		
	Dhysisian		23a, Pag I, Enter the disease.	or complications that	caused the death	Do not enter t	he mode of dyin	g, such as	cardiac or	respiratory a	rrest, sho	ck, or hear	Ap	proximate Interval		
	hysician Medical		23a. Pad I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death													
	≟xaminer	- 1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):													
				h	2 001304001100 0	,,,,										
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of	of):										
		Examiner	cause, Enter Underlying Cause C.													
	# K/&	ä	events resulting in death) Last Due to (or as a consequence of):													
	760, icate be executed physician and the burial - transit			d.												
	D, be ey siciar	Physician/Medical	UNPENDED	AMENDED							1004	I. Date of d	olivon			
	760, ficate b g physic t the bu	Ě	IF FEMALE: 23b. Was decedent pregnant in		s, outcome of preg	gnancy	etal death	3 Ectop	ic pregna	ncv		Month	Day	Year		
	certification of the second of	ä	past 12 months?		gnant at time of de		ther (Specify)				- 1					
	P.O. Box 68: that the death certifined by the attending detached for use as 1	ysi	1 Yes 2 No 9 U	nknown 9 Unk	nown						1					
	t the		Part II. Other significant cond	litions contributing	to death but not	resulting in the	underlying caus	e given in F	Part I.		_		_	ause of death?		
	PO	l by								1'`	Yes 2 ✓	No 3	Probably	4 Unknown		
	ords, w requir as been s should b	Completed by								24a. Wa	as an topsy			findings available etion of cause of		
	law r has b	npk								pe	rformed?	de	ath?			
	tal Recian: The certificate ector, page	Cor	25. Was case referred to medical 26. Place of Death (Check only one)									0 1	1 Yes 2 No			
	Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medie examiner?	Hospital:	1			Other ₄		g Home 5	Reside	nce 6	Other:			
	Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sied in by the finneral director, page 2 should the country page 3 s	2	1 ✓ Yes 2 No		Inpatient 2	28b. Time of		njury at Wo		28d. Descri						
	ding Phy		27. Manner of Death 1 Natural 5 Pe	ECYMR	te of Injury nth, Day,Year) ID:	FOUND:				Subject h			•			
	ior Itend Ieath tor:	atic	1 Natural 5 Pending Investigation FOUND: 1 Yes 2 No Natural 5 Pending Investigation 1750 hrs 1 Yes 2 No Natural 5 Pending Investigation 1750 hrs 1 Yes 2 No Natural 5 Pending Investigation 1750 hrs 1 Yes 2 No Natural 5 Pending Investigation 1750 hrs 1 Yes 2 No Natural 5 Pending Investigation 1750 hrs 1 Yes 2 No Natural 5 Pending Investigation 1750 hrs 1 Yes 2 No Natural 5 Pending Investigation 1750 hrs 1 Yes 2 No Natural 5 Pending Investigation 1750 hrs 1 Yes 2 No Natural 5 Pending Investigation 1750 hrs 1 Yes 2 No Natural 5 Pending Investigation 1750 hrs 1 Yes 2 No Natural 5 Pending Investigation 1750 hrs 1 Yes 2 No Natural 5 Pending Investigation 1750 hrs 1750 hr								as Dural P	outo Number City				
	or Ar	ific	3 ✓ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.							or Town 7210 Dunw	n (Street a n, State)	na Numbe	NAD.	oute Number, City		
	Divisopital or A hours after meral Dire	Certification:	4 Homicide		y Single Fa											
29a. Certifier (Check only one) 29a. Certifier 2 29a. Certifier 3 29a. Certifier 3 29a. Certifier 4 29a. Certifier 4 29a. Certifier 5 29a. Certifier 6 29a. Certifier 6 29a. Certifier 7 29a. Certifier 7 29a. Certifier 8 29a. Certifier 8 29a. Certifier 9 29a. Certifier 9 29a. Certifier 9 29a. Certifier 1 29a. Cer									ause(s) an	nd manner:	as stated. ie to the cai	ıse(s)				
DIVISION OF AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 1																
	L > F 3	ž	29b. Signature and title of cert	tier	11			ense numbe	er'				d (Month, l	vay, i €di)		
	,			· M.	11	/	0.	C.M.E.			Jun	e 22, 20	00			
	6		30. Name and address of pers													
	y		Jack Titus MD. D	eputy Chief Me	dical Examine		enn Street, E	Baltimore	, MD 21	1201						
	S	tate	31. Date filed (Month, Day, Yea		Registrar's Signa	ture	1.5									
	Regis			ATTICK A Boat	Peters J.J.	Edit Maria	No.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** LU HONGHAI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Health & Rehab Ellicott City Howard If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye 3/8/1930 5. Social Security Numbe 6 Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. Months 214-31-1902 1**X** M 2 □ F China 78 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a, State 10d. Inside City Limits MD Howard Director Columbia 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be n 7080 Craddlerock Way 21045 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status ural", or item Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examinen ones. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: Chinese 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chairman Printing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unavailable unavailable 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Xing Ying Yu/wife 7080 Craddlerock Way Columbia MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nation 3 ☐ Removal from State 6/26/2008 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD Meadowridge Cemetery 22. Name and Address of Facility Gary L Kaufman Funeral Home 21. Signature of Funeral Service Licensee 7250 Washington Blvd Elkridge MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End Stage Chronic DIOUX /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Box 68760. use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.O. I been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s autopsy 1☐ Yes 2 No or Attending Physiclan: 25. Was case referred to medical examiner? director, Certification: To Be 26. Place o Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 16 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day Year) funeral 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, within 24 hours after death.

To the Funeral Director; / Hospital To the Hospital within 24 hours a To the Funeral I

> State Registrar

31. Date filed (Month, Day, Year) JUN 2 5 2008

29a. Certifier



SVITE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NL,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

053987

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20560 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Lee Lea 18:03PM Brenda TUNE 2008 20 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Agres BALTIMORE HOS DITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days Hours Min. 1 □ M 2**X** F 216-58-2054 60 b6 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 □ No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3059 Clifton Ave 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2√2 Married 1 □Yes 2 No Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beth Steel Corp. Steel Worker <u>12th grade</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lawrence Clinkscales Lucille Henderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7520 Shelowood Road, Pikesville, Md 21208 Darrell Lea-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 6/25/08 Woodlawn, Md 21. Signature of Fineral Service Licus March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemic 02 day disease or condition resulting in death) Due to (or as a consequence of): Septic Shoc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒️vo 24a. Was an 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 → Anpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

 \mathcal{L}_{cc} / $\mathcal{E}\mathcal{R}$ そ \mathcal{N} A 、 Division of Vital Records, P.O. Box 68760,

be executed burial-transit and physician at the burial use as To the Hospital or Attending P within 24 hours after death.

To the Funeral Director; After t completely filled in by the funera

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Physician

/Medical

Examiner

Examiner

Physician/Medical

2

Completed

Certification: To

Medical

3altimore, Maryland 21215-0036

/Medical

Director

BENRADUANE

P22256

HOSPITAL

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) June, 20, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SI Agnes BENRADUANE

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ASSITER SUD Zeu ? 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death OSPINAL BAUTHORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days Hours 1 XM 2 ☐ F Yrs. 239-32-2988 82 1-29-1926 NC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5507 BELLEVILLE AVENUE 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 👿 No Specify: 3 XWidowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RESTAURANT COOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **GURNIE** LASSITER MARY JENKINS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD TAYLOR/BROTHER-IN-LAW 5507 BELLEVILLE AVE. BALTIMORE, MARYLAND 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 4 Donation 5 Dother (Specify) **METRO CREMATORY** 6-27-08 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. or. 1701-31 LAURENS ST. BALTIMORE, MD 21217 Approximate Interval Between Onset and Death 23a. Ptr.f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequince of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 - No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[]N 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

/Medical Examiner the death certificate be executed burial-transit P.O. Box 68760. attending physician the as for Division or Vital Records,

Physician

Physician

/Medical

Examiner

Funeral

Director

show r 28a-f show notified at

ir than "natural", or items 23a or the Medical Examiner must be

Maryland 21215-0036

Baltimore,

72 hours

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other than any Injury or other treasment.

Director

Funeral

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Completed

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Examine

Physician/Medical

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Completed

Be

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Certification:

Medical

State Registrar

ed by the a signed by been To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this \ completely filled in by the funeral dir

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

5 Pending investigation 6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

05E726 501

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST. PAUL PLACE BAUTNORE

and manner stated.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 9384 M 12008 **Physician** TUNE ADOR LOPET /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY BALTIMORE GOOD SAMARITAN HOSPITAI 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Hours Months Days 265-50-7784 **X**M 2□ F Puerto Rico 75 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises and be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Yes 2□No Baltimore N/A Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21206 Road 4917 Greencrest Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Specify Puerto Rican 1 ☑ Yes 2 ☐ No Baltimore, Maryland 21215-0036 <u></u> 3 Widowed 4 Divorced 16b. Kind of Business/Ind. stry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and B Auto entary/Secondary (0-12) 8th grade College (1-4or 5+) Clerk Supplies 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecilia Ramos Lorenzo Lopez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4917 Greencrest Road Baltimore, Md 21206 Ana Jackson/ Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Greenmount Cemeter 6/21/08 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature Fu eral Service Licensee 4210 Belair Road Baltimore, Maryland21206 Yark lon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL 4CUTE /Medical Due to (or as a consequence of): Examiner ARDIOVASCULAR BATHEROSCIEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical IF FEMALE nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐Yes 2 ☐ No certificate 2**X**No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 2 ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗍 Inpatient 1 ☐ Yes Certification: To After this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Manner of Death 28a. Date of Injury (Month, Day, Year) Injury Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide completely filled in by determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

State Registrar 31. Date filed (Month, Day, Year)

KER I TH

29b. Signature and title of certifier

5601 LOCH JUSE 32. Registrar's Signature JUN 2 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29c. License numbe

RAVEN BLUD, BALTIMORE MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 2008 6:30 AM 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 201 F 219-60-882 92 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or 23a 2123 Funeral Huenue or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: þ If Yes, Give Tear or Dates: 3 ₩ Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exwhite Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BigFalls eBrun Monkton Howard mD 21111 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bel Air Memorial
Gardens Cemetry 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-28-08 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Parkuille
2800 Harbord Rd. Parkuille mb 21234 21. Signeture of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): PERITONITIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PERFOR ATION requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s autopsy page performe certificate 21 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this of funeral dire 1 🔽 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death. leral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Records, Division of Vital Hospital or Attending Physician: within 24 hours a

To the Funeral C

completely filled

Box 68760,

P.O.

State Registrar

KIYANKA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JUN 2 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

5601

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LOCH RAVEN BLVD, BALTIMORE, MD 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 **Physician** Sylvia Lane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSPITAL BALTIMORE ST AGNES MI If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 215-74-1203 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 😾 F 47 Director April 24, 1961 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eximiner must be notifiled at 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location MD Baltimore 1-Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 N. Payson Street. 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 270 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify. SpecifyAfrican American þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 sign painter Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gentle J. Lane Estel Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Walker / Brother 3552 Ady Road; Baltimore, Maryland 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mount Zion Cemetery 06/28/2008 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 wer 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PMEUMONIA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year 4□Pregnant at time of death 9□Unknown Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No The law requires that the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown REMAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy perform ial or Attending Physician: T s after death.

I Director: After this certificate in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number P 2 2 2 5 3 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month, Day, Year) JUN 2 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

I AMTO HHANE DIMAN. 900 S. CATON AVENUE, BALTIMORE, MD 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** 23. DORIS MAE MILES June 8:45 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Min. 1 □ M 2√2 F Hours 1919 215-18-0367 89 May 19, Maryland Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mertal Hyglene. The marked other than "natural", or Items 23a or 28a-f show ther than "natural" or Items 20 or 2 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐Yes 2☐No Director Maryland Montgomery Burtonsville 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 14828 Old Columbia Pike 20866 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 XXIVo Specify: q Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Grade 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unknown) Miles (unknown) (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: If Item 27
any Injury or other tn Bill Miles 2930 Miles Road Burtonsville, Maryland son 20866 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State West Arundel Crematory 6/27/08 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed s attending physician resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 Yes 2 VNC 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 □ Yes 2 □No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1.☐ Impatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending death, 1 ☐ Yes 2 ☐ No 2 Accident the after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifier 1 Secrititying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b, Signatur

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Maryland 21215-0036

Baltimore.

P.O.

Records.

of Vital

Division

State Registrar

filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
APRIL 1144 195, per H. 080, 6/25/08, W.
State of Maryland / Department of Health and Mental Hygiene. Reg. No. 2008 20566 State Registre Amend 3, perMD, g881, 7/1/08 Treatificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 21 orne lius 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arunde Arundel Anna poliS Inder 1 Year | If Under 24 Hrs Medical 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 10 M 2 F Months Hours Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f ahow other traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 DNo MD Director Anne Arundal denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With J.S.A baman tha Lane Items 23a 1013 21113 Funerai Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Harried Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☐ No Specify: Black Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) s and Mental Hygiene. Colfege (1-4or 5+) aborer Bethleham Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ornelius Stepner Maddox -ucille 2 19b. Mailing Address (Street an Number or Rural Route Number, City or Town, State Zip Code)

Samantha D. Odenton, MD 21113 nt of Health Maddon xanita 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 Decremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Page Depertment of Important: If any injury or once. Greenmount Cemetery 6.26.2008 Baltimore, MD
22. Name and Address of Facility Vaugna C. Greene Funeral Services 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens Vaughn C. Pheore 4905 York and Bultimore 7

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York And Bultimore, MID 21212 Approximate Interval Between Onset and Death fmmediate Cause (Finaf **Physician** Obstructive Lung 710y Tronic disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events nding physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2□No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 2 NO 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Dea 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pendina within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29s Certifier Certifying Physician: To the best of my knowledge, feath congred at the time, date and place, and due to the causels) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier D 24804 my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Petorson wis Annychy Md 21401 AAMC 31. Date filed (Month, Day, Year)
JUN 2 5 2008 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl

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Exami Funera Director	ner	4a. Facility Name (If not institution, give so Collington Episco) 5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	pal Life Care	as <i>t birthday)</i> Yrs.	If Under 1 Year If U	ation of Death 211vi11e Under 24 Hrs. Durs Min.	3. Date of Birth (Month, Day, Ye 10/9/19	ear)	9. Birthpla	erge's ce (State or F	Foreign	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Joan M. Mortillaro 2008 5:16 P. June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 184 Clemencia Road Cecil Earleville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01/30/1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 □ M 2 🕱 F England 218 26 3723 85 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10h County 10a State other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be retified at 1 □Yes 2 X No Ceci1 E1kton Funeral Director Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21921 U.S.A. 74 Woods Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2 No Specify. Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7:
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Important: If item 27 is marked other than "n any Injury or other traumatic event, Ins. Madione. Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Frederick Wright Jane Marvann Morton ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elkton, Maryland 21921 Paul Mortillaro / Husband 74 Woods Way 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State State Veteran Cem.06/23/2008 | Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🛂 No Day 5 ☐ Other (specify) signed by the a 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying sause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform certificate 2 □ No 1 ☐ Yes 2 K No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) DAUG KTER'S Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To Home 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 20649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 4902 Towson, Maryland 21204 6701 N. Charles Street John W. Bowiem M.D. 32. Registrar Signature 31. Date filed (Month, Day, State 2000 Registrar

08-04735 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Michael McHale 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1645 hrs June 19, 2008 Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) RandalIstown **Baltimore County** Northwest Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Days Min Hours Months Director Country) 1 MM 2 F 567-49-8206 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Ves 2 No 28a-f show death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 21666 23a 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status White, etc. Armed Forces? 2 Married Never Married 2 Yes permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" on f Yes, Give Yeer Yes 2 No specify: white Specify 3 Widowed Divorced 2 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Home 0 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 111 Be Taina James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stevensville, MD 316
Date | 20c. Location - City or Town, State Shecr Bd MD 21666 Spouse ove Point 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Balto, MD Crematory 30-08 Donation 5 Other Specify 22. Name and Address of Facility 21. Si wure of Funeral Service Lucrise shock, or heart roximate Interval 1230 Midvalla 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and ure. List only one cause on each line. /Medical Tramadol intoxication complicated by dilatated cardiomyopathy Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial - transi Physician/Medical AMENDED 23a, 27, 28a-f, perME, g882 8/8/08 TT **X** UNPENDED Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnance 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. signed by 1 Yes 2 No 3 Probably 4 V Unknown ⋧ Completed 24b. Were autopsy findings available peen 24a. Was an prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No 1 🗸 Yes this certificate Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other₄ Nursing Home 5 Residence 6 Inpatient 2 🗹 ER/Outpatient 3 DOA 1 Yes After 1 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natura 1X Yes 2 No 5 Pending unk 6/19/08 FNd 3:55 pm Fnd within 24 hours after death To the Funeral Director: in by the Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 Woodchester Ct. Pikesville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide (Specify) found in house Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d, Date signed (Month, Day, Year) 29b Signature and title of certifier 29c. License number June 20, 2008 O.C.M.E Ω 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 31. Date filed (Month, Day oistrar's Signatur State 2008 Registra

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 21, 2008 **Physician** 9:30 AM James R. McCrumb, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6601 Green Valley Road New Market Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Mar 21, 193 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 74 Director 218-36-9179 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, ih Medical Examiner must be notified of once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County MD Frederick New Market 1 ☐ Yes 2 🛣 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21774 6601 Green Valley Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Y⊟Yes 2 No fryes, Give Year or Dates: 1956-57 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Educator/ Principal Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Phebe Riley ဂ္ Fred Rodgers McCrumb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joan Clayton McCrumb (Wife) 6601 Green Valley Road New Market, MD 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 6/24/2008 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 Dage Haight Herbert 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a const quence of): /Medical Examiner nul mon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś more 1æYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2₽No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 14 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Vithin 24 hours are To the Funeral Dir 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00006 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:56 PM Juliet McQueen 4a. Facility Name (If not institution, give street and number) June 22, 2008 4c. County of Death /Medical 4b. City, Town, or Location of Death Examiner Baltimore 9. Birthplace (State or Foreign Country) 1102 Hartland Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 3 F Director 122-34-8579 Usual Residence of Deceden 64 07/07/1943 NC death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Directo MD Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1102 Hartland Road 14. Race - American Indian, Funeral 21221 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Self Employed Elementary/Secondary (0-12) College (1-4or 5+) Beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Benjamin McQueen Valdeaner Windom 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trent McQueen/Son 3023 Bero Road Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐Removal from State Jun 24 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 22, Name and Address of Facility 2008 21. Signature of Funeral Service License M014 Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. roxima e Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Squamous cell concer of Physician /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe this certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death after death Director:

within 24 hours a To the Funeral L

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

on

JUN 2 5 2008

29a. Certifier

Medical

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OTTAV. AND MD 9103 Franklin Squar Dr. Backmar MD 21237 JUNNE

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

140850

29d. Date signed (Month, Day, Year)

June 23, 200 P

			For State Registrar	State of Maryla	•	artment of F ertificate of I				2008	20573
	Physici	an	1. Decedent's Name (First, Middle, La	*	ACUI TO			2. Date of Dea Month	Day 22,	2008	3. Time of Death
· Second	/Medic	al	ROSALYN 4a. Facility Name (If not institution, given		MEKLIR	4b. City, Town, or	Location of Death	JUNE		2008 county of Death	10:30 A M
2	Examili	er	SOMERFORD PLACE	ASSISTED LIVI			JMBIA		1	HOWARD	
	Funeral Director		0.0 20 7001		s. last birthday 81 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month Da 5/17	71927	9. Birth	place (State or Foreign intry) MI
	land ow		Usual Residence of Decedent 10a. State 10b. County		City, Town or L	ocation					10d. Inside City Limits
	e Mary 3a-f sh liffed	Director	MD HOWAR	D .	COLUI	MBIA					1 □Yes 2 X No
	th with th 23a or 29 ast be no		10e. Street and Number 10272 WAYOVER W	/AY		10f. Zip Code 21	L046		•	en of What Cou USA	intry?
036	be filed within 72 hours after death with the Maryland tial Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Event her must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Amer Black, White, Specify:	ican Indian, etc. VHITE
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ar y	should and Men s marke	욘	JOSEPH 19a. Informant's Name/Relationship		TMAN 19b. Mail	ing Address (Street	MARY and Number or Ru	ral Route Numbe			
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Baltimore, Maryland 21215-0036	Pages 1		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Contents)		20c. Location - City or Town, State PENNSAUKEN, NJ						
Ball	permit. Page Department Important: If any injury o		21. Sign fure of Funeral Service Lice	mspe elle		22. Name and Addre	SC	L LEVIN ROAD P			, INC. MD 21208
-	Physician		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.		nter the mode of dyir					Approximate Interval Between Onset and Death 3 YEARS
r	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):						
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90,	fficate be executed g physician and is the burial-transit	ıl Examiner	that initiated events resulting in death) Last	C Due to (or as a conse	-						
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O. Box	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	☐ Ectopic pregnanc ☐ Other (specify) _	Sy		23	3d. Date of deli Month	very Day Year
ds, P.	uires that the de η signed by the ε Id be detached f	by	Part II. Other significant conditions Hypertas. De	-	esulting in the	underlying cause giv	en in Part I.	23e. Did t	1	,	the cause of death?
Division of Vital Records,	The law requir ate has been s page 2 should l	Completed	Depression Oskoporosis.					24a. Was auto perfo		prior to death?	topsy findings available completion of cause of
Vita	iclan: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		ont 3 DOA Oth	26. Place of Dea			N.c.	Assisted
n of	ding Physiclan: The lav h. After this certificate has funeral director, page 2 a	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time	of 28c. Inju	ry at k?	ome 5 Resi 28d. Describe		Other (Specoccurred	city) Elving
Divisio	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification: To	2 Accident investigation 3 □ Suicide 6 □ Could not to 4 □ Homicide determined	e 28e Place of Injury - At			Yes 2□No	28f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Number,
	Hospita 24 hours Funeral etely fille	Medical C		hysician: To the best of my k miner: On the basis of exami							
	To the within To the compl	Me	29b. Signature and title of certifier			29c. Licens		-		signed (Month	0
	20		30. Name and address of person who	completed cause of death (It	em 23a) (Type		16855		6	23-0	5
	7		Shoron Filmer	non MD							
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Sig							

	ı T	State Registrar I. Decedent's Name (First, Middle,	Last)	-	Certifica	ale or Di	eau i	2. Date of De	ath	2008	205 3. Time of Death
ian	1	Sheila N	1 (DWENS				June	18_	2008	2252
ica nei		a. Facility Name (If not institution,	give street and number of Mouryland		Center 4b. C	Baltin	ocation of Death			nty of Death	
		214-64-5822	5. Sex / 7 1 □ M 2 x 2xF	'. Age (In yrs. last) 51	yrs. If Un Month		f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug. 2,	th ly, Year) 1956	9. Birthp Coun	lace (State or Forei try) MD
,	1	Usual Residence of Decedent Oa. State 10b. County		10c. City, To	own or Location Baltin					10	0d. Inside City Lim
ironto	ll ecro	MD Oe. Street and Number				Zip Code	002		10g. Citizen	of What Coun	
C. C. C. C.	letal .	526 N. Scroeder Str	12. Was Deced	lent Ever in U.S.	13. Was De		223 Danic Origin? (S	Specify Yes or No to Rican, etc.))- 14.	Race - Americ	
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6	n n	17. Father's Name (First, Middle, L	ast) S Owens, Sr.				8. Mother's Nar	me (First, Middle Ella Louis	, Maiden Sur		
1	0	19a. Informant's Name/Relationsh Tanisha Hughes / Da	p (Type. Print)		19b. Mailing Addr 2418 Fea			ural Route Numb altimore,			
		20a. Method of Disposition 1 → Burial 2 □ Cremation		20b. Place ceme	e of Disposition (etery, crematory			Date		on - City or To	wn, State
	ŀ	4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L	ecify)	Mount		and Address	of Facility Wy	4/2008 lie Funera Baltimore	al Home,		
	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o. Injury that initiated events resulting in death) Last	b	or as a consequent or as a consequent or as a consequen	ce of):						
78.8	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	come of pregnancy irth 2 Petal de ant at time of deat own	eath 3 🗌 Ectop	ic pregnancy (specify)			23d	. Date of deliv Month	ery Day Year
	2	Part II. Other significant conditio	ns contributing to de	ath but not resultin	ng in the underlyi	ng cause giver	n in Part I.			contribute to t No 3□ Pro	he cause of death bably 4 🗗 Unkr
	Completed							1 □ Yes	opsy formed? 2 No	24b. Were auto prior to co death? 1 □ Yes	opsy findings avai ompletion of cause 2 □ No
10	n: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date o	npatient 2 EP	R/Outpatient 3 D	Other	4 □ Nursing	Home 5 Res 28d. Describe	sidence 6		ify)
	Certification: To	1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ation	of Injury - At home		es 2□No	28f. Location City or To	(Street and Nown, State)	lumber or Rui	al Route Number,	
	Medical C	29a. Certifier (Check only one) 1 Certifyin 2 Medical	g Physician: To the Examiner: On the ba and manr	best of my knowle asis of examination ner stated.	edge, death occu n and/or investiga	rred at the tim ation, in my op	e, date and pla inion, death oc	ce, and due to th	e cause(s) ar e, date and pl	nd manner as ace, and due	stated. to the cause(s)
		29b. Signature and the of confifie	02 -//			29c. License	number		29d. Date s	signed (Month	, Day, Year)
	Me	Mirhat	Kanilla	A same		P2	1171		dien	0, 18	200 imore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Jonth** Year **Physician** CELIDA 2008 P0550 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE NOTETHWEST HUSPITOL HUSPICE UNIT RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 2 🗹 F Months Days 581-70-2551 PUERTO RICO Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 21 No BALTIMORE WINDSOR Directo MD MILL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21244 USA CITA, CACS 74106 FAIRBROOK Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FABRIC SEAMSTRESS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNK 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) "> 13 44 FAIRBROOK ROAD APTID, WHOSORMILLIND DRMANDO HUSBAND 7406 POSSO, TR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State MANOUR, MARTIAND 4 ☐ Donation 5 ☐ Other (Specify) ARDENT CIDENATORY JUNE DS, DOOR 22. Name and Address of Facility
ARDSUT COSMATION 21. Signature of Funeral Service Licensee STEN, HAWVER, MD CONNELLEY DR 7522 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a jich line. Immediate Cause (Final disease or condition resulting in death) Ancrea Dus to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death

Physician /Medical Examiner

Funeral

Director

28a-f show

6

items 23a

,0

"natural",

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Item Monce.

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

physician and the burial-transit certificate I Director: A

₽

Completed

Be

Certification: To

ical

State

Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760,

in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

5 Other (specify).

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes

2 No 3 Probably 4 ☐ Unknown

24a. Was an autopsy 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NosPico 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

27. Manner of Death 1 Natural
2 Accident

3 Suicide

4 Homicide

5 Pending

investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

determined

28a. Date of Injury (Month, Day, Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

30. Name and address of person who se of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) JUN 2 5 2008

29b. Signature and title of certifier

MO Registrar's Signa

within 24 hours at To the Funeral D completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:30 8 15 Edward Peterson John /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore NA Baltimore VA Medical Center If Under 24 Hrs Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number Age (In yrs. last birthday **Funeral** Months 1€M 2□ F 579-22-5884 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r 28a-f show notified at Baltimore 1 HYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number ь ıral", or items 23a or I Exaπiner must be Lambeth 21218 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Des 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ould be f ages 1 and 2 should be nt of Health and Menta t: If item 27 is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nd Baltmore Gibson arry Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ment of F on Forest 6/23/2008 Baltimore MD
22. Name and Address of Facility Yaughn C. Greene Funeral Services Parial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Garrison Forest 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 4905 York Ad Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NON small cell lung cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2M No 1 Yes Hospital or Attending Physician: filled in by the funeral director, 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death after death. (Month, Day Year) 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral L Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, JUN 2 5

DHMH 17 Rev 1/2001

M.D.

32. Registrar's Signature

Quinones

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mercedes

Year) 2008

AU 4176435Q16590

10 North Greane Street Baltimore

29d. Date signed (Month, Day, Year)

06-15-2008

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6820AM 20 Helen Deanna Page June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Lanham Doctors Community Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1 □ M 2 🖾 F 7/13/1946 Riverdale, MD 213-46-5712 61 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 10a State Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examination and Lear office at once. 1 √Yes 2 No Director MD Prince George's Bladensburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20710 United States 4201 52nd Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Helen Marie Cline Eugene Paul Linkous 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4201 52nd Street, Bladensburg, MD 20710 Bearl Page, Sr. / husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/23/08 Brentwood, MD Fort Lincoln Cemet. 22. Name and Address of Facility 4739 Baltimore Avenue 21. Signature of Funeral Service Licenses Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus _____ each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Prespira tor /Medical Due to (or a a consequence of): Examiner long Reasons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed neumon and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>&</u> 1 | Yes 2 | No 3 | Probably 4 | Winknown After this certificate has been s funeral director, page 2 should it Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2∐-Ko 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06/21/02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Luck Road. Lanham ASIKA 112ABSH1 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

Physician /Medical Examiner **Funeral** Director should be filed within 72 hours after death with the Maryland ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Macical Examiner must be retified at Director Funeral Baltimore, Maryland 21215-0036 þ Completed and Mental Hygiene. Be ပ Health a permit. Pages 1 an Department of Heal Important; If item 2 any Injury or other **Physician** /Medical Examiner

burial-tran The law requires that the death certificate be execu Box 68760, as nse ģ P.O. Vital Hospital or Attending Physician: funeral director, Division of After this

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Examiner Physician/Medical <u>م</u> page 2 should be Be Completed Certification: To within 24 hours after death To the Funeral Director: filled in by Medical

1. Decedent's Name (First, Middle, Last) 1:30a.M Pee 19 2008 06 Catherine 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Joseph Richey Hospice 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Days Hours Min. 1 □ M 2 🖫 F 43 NC 09 212-40-0360 64 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County No 2 No Baltimore NA MD 10g. Citizen of What Country? 10e, Street and Number 21207 U.S.A. 2906 Oakhill Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 | Yes 2 | No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
10th grade College (1-4or 5+) College Manor Assistant Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rebecca McIver Lewis Potts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21207 2906 Oakhill Ave, Baltimore, Md Robert Pee-Husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/27/08 Baltimore Co, Md Woodlawn 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West Topette 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chine. Immediate Cause (Final disease or condition resulting in death) Due to (or as a con equence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy Month in the past 12 mog 5 ☐ Other (specify) 1 ☐ Yes 2 DNo 9 Unknown 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 hknown 1 □ Yes 2 □ No Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 1 □ Y96 25. Was case erred 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Y9 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 6 Ther (Specify) er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month Day, Year) 29b, Signature and title of Regist State Registrar

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permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Phys /Me Exa

	for State	state of Ma	ryiand /		tificate of l		nd Mental Hy	Reg. No.	0000	2057		
	Registrar 1. Decedent's Name (First, Middle, Last)			061	incate or i	204111	2. Date of D		<u> </u>	3. Time of Death		
ın							Month	Day 23 rd	Year 2008	7.00 A		
al .	Helen B. Pearce 4a. Facility Name (If not institution, give stre				4b. City, Town, or	Location of I			ounty of Death			
er	Upper Chesapeake N		enter		Bel A			I	Harford	ĺ		
	5. Social Security Number 6. Sex		(In yrs. last b	irthday)	If Under 1 Year	If Under 24		rth	9. Birth	place (State or Forei		
		1 2×2√F	80	Yrs.	Months Days	Hours	July 2	7, 192		Maryland		
tor	10a. State 10b. County Maryland Harford		10c. City, Tov Jan		sville					10d. Inside City Limit		
al Director	10e. Street and Number 2029 Cox Road				10f. Zip Code 2108	4			en of What Co ced Sta America			
Funeral	11. Marital Status	. Was Decedent E Armed Forces?	ver in U.S.	13.	Vas Decedent of H	ispanic Origi	n? (Specify Yes or N Puerto Rican, etc.)	0- 14	 Race - Ame Black, White 			
by Fu	1 Never Married 2 Married	1 ☐ Yes Ş∰N If Yes, Give Year or Dates:	O		□Yes 🏋 No	Specify:		1		hite		
Completed	15. Decedent's Educa (Specify only highest grade of		16	a. Deced (Give	lent's Usual Occup kind of work done OO NOT use retired	eation during most o	of working	16b. Kind	d of Business/	Industry		
dmi	Elementary/Secondary (0-12)	College (1-4or 5-	+)		ecretary			_ c	office			
	17. Father's Name (First, Middle, Last)					18. Mother	s Name (First, Middi	e, Maiden S	lurname)			
) Be	George Washington	Burton				Mary	Elizabeth	Dedde	3Ľ			
ို	19a. Informant's Name/Relationship (Type	e. Print)	19		=	and Number	or Rural Route Num	ber, City or	Town, State, 2			
	Marybeth Blom/ daughter 2031 Cox Road Jarrettsville, Maryla 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Removal from State 3 Removal from State											
	20a. Method of Disposition 12											
V. 1	23a. Part 1. Enter the disease, or complete shock, or heart failure. List only one	1	the death. De	1	2325 Yor	k Road	Timoniu	m, Mai	&Cremat ryland	21093 Approximate Interval Between Onset and Death		
e i	Immediate Cause (Final disease or condition	Acute			ceilure					10 day		
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that initiated events resulting in death) Last Due to (or as a consequence of):										More H		
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Miles 1 Ves 2 Miles 2 Miles									3d. Date of de Month	livery Day Year		
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0	27. Manner of Death 1 KlNatural 5 □ Pending	28a. Date of Inju (Month, Da		b. Time (Injury	We		28d. Describ	e how injury	y occurred			
은	1 Natural 5 Pending (Month, Day Year) Injury Work?									Rural Route Number,		
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Certification: To		Ician: To the best	of examination	dge, dea	th occurred at the nvestigation, in my	time, date an opinion, dea	d place, and due to t	he cause(s) ne, date and	and manner a place, and du	as stated. ue to the cause(s)		
은		Ician: To the hest	of examination	dge, dea and/or i	nvestigation, in my	time, date an opinion, dea	d place, and due to t th occurred at the tin	ne, date and	place, and di	as stated. ue to the cause(s) nth, Day, Year)		

Registrar DHMH 17 Rev 1/2001

State

UPPER

M.D.

82. Registrar's Signature

BANGORIA

JUN 2 5 2008

KAMAL

31. Date filed (Month, Day, Year)

CHESAPEAKE MEDICAL

BELAIR,

CENTER,

AMEND TTP://#20b.perFH.0880.6/25/08.WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ital West HOSP OL arNL 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Days Hours Months Director Douth Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director ikes ville 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 X40 Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Disabled 12-17 17. Father's Name (First, Middle, Last). 18. Mother's Name (First, Middle, Maiden Surname) -Ugenl 201 00150 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) loria permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other once. 20a. Method of Disposition Place of Disposition (Name of Trinity Cemetery Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify)

21. Signature F eral Service tites -26-08 ansdowne, mD Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseas) or condition resulting in death) FAILURE RESPIRATORY **Physician** /Medical Due to (or as a consequence of) PESPIRATORY DISTRESS SYNDROME Examiner E-quentially list our diture, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ONEUMONIA anding physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has l page 2 s autopsy performe 2**X**No 1□ Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Compared to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 FRANCIS KHOO, MD 200 MEMORIAL AVE, WESTMINSTER, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 JUN 2 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra Amend 19a, perFH G881 7/2/08 Togertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ine 2008 <u>Irma Bernetta Randolph</u> /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Doctors Hospital Lanham If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🖫 F Months Days 1941 Illinois Director Feb. 28, 327-34-1719 67 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location if them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evantral rust be notified at 1 □Yes 2 No Funeral Director Maryland Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? USA 11718 Tuscany Drive 20708 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married <u>م</u> 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Dept. of Justice Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill h and Mental F. Is marked ott Be Lorraine Mildred Payne Homer Raspberry Stinson, Jr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health stem 27 ls 11718 Tuscany Drive, Laurel, Maryland 20708 Robert Randolph- son husband permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 30,2008 Lombard, Illinois Trisons Crematory 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility Fleck Funeral Home, INC.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Appropriate Cause (Fine) Approximate Interval Between Onset and Death Immediate Cause (Final BREAST CANCER METASTATIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNG METASTASI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician ned for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PULHONARY FIBROSIS ⋛ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed CARDIOMYOPATH 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier pleted cause of death (Item 23a) (Type, Print 30. Name and address of person who POINT DR. GLEENBELT, MD 20770 7831 BELLE HELVIN GASKINS, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2008

JUN 2 5

			State of Maryland / Department of Health and Mental Hygiene 1- For amend #9,10a,11&19b Per FH G8806 Certificate of Death Reg. No. 2008 20582
	Physici /Medio		1. Decedent's Name (First, Middle, Last) JAMES RICHARDSON 2. Date of Death Month Day Year JUNE 19 2008 3.15A M
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4d. County of Death
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	Usual Residence of Decedent 10a. State
Maryland 21215	ould be filed within 7 Mental Hygiene. arked other than "n atic event, the Medi	To Be Completed	(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Standard Manager 17. Father's Name (First, Middle, Last) Lewis Harry Richardson (Give kind of work done during most of working life. DO NOT use retired) Manager 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Mary Papoi
Baltimore, Mary	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is marke any Injury or other traumatic once.		19a. Informant's Name/Relationship (Type. Print) John Zaucha/ Partner 20a. Method of Disposition Burial 2 Gremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory Inc. 2008 Beltsville, Maryland
760,	Hilicate be executed / Medical Examiner Physician and Physician and Physician and Physician are the burial-transit	Medical Examiner	23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last List only one cause on the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death doubt of the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death doubt of the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death doubt of the mode of dying, such as cardiac or respiratory arrest, shock or respiratory a
P.O. Box 68	the death cely the attendir tached for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown
Vital Records, F	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Completed by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1
of	ding Physician: h. After this certifica funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 Yes No 1 Yes 2 No 1 Yes 2 Yes No 1 Yes Yes No 1 Yes 2 Yes No 1 Yes Yes No 1 Yes Yes No 1 Yes Yes Yes Yes No 1 Yes Yes Yes Yes No 1 Yes Yes Yes No 1 Yes
Division	Hospital or Atteno 24 hours after deat Funeral Director: stely filled in by the	al Certification:	3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital within 24 hours. To the Funeral I completely filled	Medical	(check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WEDICAL DOCTOR RES - 000 JUNE 19, 2008
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SENVICES ANN YATES 600 North Wolfe St, Baltimore, MD, 21287
	Sta Regist		31. Date filed (Month, Day, Year) JUN 2 5 2008 32. degistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2^{Day} 2008 **Physician** June 7:15 A^{M} /Medical Marjorie Mae Reese 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months 1 □ M 2 🖫 F Yrs. 83 08/29/1924 WV Director 206-18-3884 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State r 28a-f show notified at 1 ☐ Yes 2 No Director Lutherville Timonium MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or must be n with 21093 Funeral 29 Croftley Road death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) of Health and Mental Hygiene.
item 27 Is marked other than "natural", or items:
other traumatic event, the Medical Examiner mu 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 9 3 Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Viola Armstrong ပ Clark McKeag 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29 Croftley Road Lutherville Timonium, MD 21093 Candace Dressel/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o once. ₽ 1 □ Burial 2 ☐ Cremation 3 □ Removal from State Jun 24 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Inc 2008 Beltsville, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01443 Cremation and Funeral Alternatives 23a. Part. Erker the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate
Interval Between
Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1

Yes 2

No 3

Probably 4

Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 200 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c, Injury at Work? Certification: After 1x Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 2 5 2008

ESE, MARJOR Maryland 21215-0036

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Itimore,

Bal

P.O. Box 68760

Records,

División or Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(AUVA DONER DONE 565 N. Charles St # 203

Baltimore MD

21204

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

Donelunno

			1 - State Amend Ite	State on 23a,P	f Marylan	d / Depa er de	artment of H	lealth ar 35/08 0	nd Me Ihb	ntal Hyg	iene _{eg. No.} 2	008	20584
	Physici /Medic		1. Decedent's Name (First, Middle, Lawrence Clay		ns, Sr.				2	2. Date of Dea Month 06	Day 03	2008	3. Time of Death 11:02 A M
	Examin	- 4	4a. Facility Name (If not institution, gi 500 Archer Str		mber)		4b. City, Town, or		Death imore		4c. Co	unty of Death	
	Funeral Director		5. Social Security Number 6. 215–40–2977	Sex MAXIM 2□ F	7. Age (In yrs. 64	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day Sept. 23	Year) 1943	9. Birthp Cour	place (State or Foreign httry) MD
	Maryland f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County MD		10c. Cit	y, Town or Lo	cation Baltimore					1	0d. Inside City Limits
	with the	Il Director	10e. Street and Number 2320 W. Pataps	co Avenue	<u> </u>		10f. Zip Code	21230		1	0g. Citizen	of What Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Nover Married 4 □ Divorced	12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	2√0xNo ve		Nas Decedent of H fYes, specify Cuba 1 □ Yes 🏚 No	ispanic Origi an, Mexican, Specify:	n? (Speci Puerto Ri	ify Yes or No- ican, etc.)		Race - Americ Black, White, ecify: Black	etc.
Maryland 21215-0036	within 72 ho iene. than "natu the Medical	Be Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+)	Give life. I	dent's Usual Occup kind of work done DO NOT use retired urity guard	during most o d)	of working		16b. Kind o	of Business/Ind	dustry
land 2	ild be filed lental Hyg ked other ic event, i	To Be C	17. Father's Name (First, Middle, Lass Lawrence Simms							First, Middle, i	Maiden Sui	rname)	
	nd 2 shou aith and N 27 Is mar ir traumat	-	19a. Informant's Name/Relationship Lawrence Simms		Son		ng Address (Street						
altimore,	Pages 1 and of Herent of Herent II item		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		State	Place of Dispo cemetery, cree tro Crem	sition (Name of natory or other place atory		Da /07/20			ion - City or To	
Balti	permit. Departn Importa any Injt		21. Signature of Funeral Service Lice	nsee On Go		22	Name and Addre		1			1117	1217
38760,	Physician /Medical Examiner but street properties of the private	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to	(or as a conseq (or as a conseq (or as a conseq	uence of): I Hype uence of).	oable Hyp Disease ertension						
.O. Box 68	The law requires that the death certificative has been signed by the attending phyage 2 should be detached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	tcome pf pregna birth 2 □ Feta nant at time of c	aldeath 3[Ectopic pregnancy Other (specify)	′			23d	. Date of delive	ery Day Year
ds, P.	uires that signed by Id be deta	þ	Part II. Other significant conditions		eath but not res			en in Part I.					he cause of death?
Vital Records, P.	The lay	Completed								24a. Was a autop: perfor 1∐ Yes	sy	24b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of 知
Division or Vit	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ition: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2350 27. Manner of Death 13250 latural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date (Mor	Inpatient 2 of Injury oth, Day Year)	ER/Outpatier 28b. Time o Injury	28c. Injur Wor	er: 4 🗆 Nurs	sing Hom	Check only or e 5 ☐ Resid 3d. Describe h	ence 6 🔀	Other (Specia	Archer St.
Divis	al or Attences after death	Certification:	3 Suicide 6 Could not 4 Homicide determined	200. Flace	e of injury - At ho ling, etc. (Specil	ome, farm, str (y)	eet, factory, office		28	Rf. Location (S City or Tow	treet and N n, State)	lumber or Run	al Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the b	e best of my kno basis of examina nner stated.	owledge, deat ation and/or in	n occurred at the til vestigation, in my o	me, date and opinion, death	l place, ar h occurre	nd due to the o	ause(s) an date and pla	d manner as s ace, and due t	stated. o the cause(s)
)	Mith To 1	Σ	29b. Signature and title of certified	wood			29c. Licens	~ ~	133	1	29d. Date s	igned (Month,	Day, Year)
			30. Name and address of person who	les Stree	t Ste. #	200 E	Print) altimore, N	Garylan d					
- 15 ₇ .	Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Signa	ature	actes.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend 4a, perDVR, 10e, perFH, C880 6/25/08 TT

Celtificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician STOKELING 5:25 a M 2008 /Medical 06 Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2608 Manhattan Avenue Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) **X**□ M 2□ F Months Days Hours Director 254-34-6102 80 06 13. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanture, must be positived at 10d. Inside City Limits Director 1

Yes 2□No MD NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1608 Manhattan Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 þ 1 ∐ Yes 2 DXNo Specify: Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witt.
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Important: If item 27 is marked other tha
any injury or other traumatic event, Italy
once. 12th grade <u>Computer Machine Operator | Social Security Adm</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Luke Stokeling Golla Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Stokeling-Wife 2608 Manhattan Ave, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National6/27/08 Baltimore, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee lakam 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Curdia anes /Medical Due to (or as a consequence of) Examiner Hypulumin Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate I 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Boonyon PUlar D19823 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOONYONG M.D 5356 RELITERS TOWN RD. BALTIMORE, MD21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 5 2008 Registrar

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			23a. Part Enter the disease, of shock, or heart failure. List	or complications that only one cause	hat caused the on each line.	death. Do not er	iter the mode of d	ying, such as car	rdiac or respira	atory arrest,		Approximate Interval Between Onset and Death
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\	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		(Check only Medic	al Examiner: On	the basis of exa	y knowledge, dea amination and/or	ath occurred at the investigation, in m	e time, date and p ny opinion, death	place, and due occurred at th	to the cause le time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
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7	77		30. Name and address of person	on w completed	cause of death	(Item 23a) (Type	e, Print)		,		,	
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	Regist	rar	2014 % 9 7	UUU JA	Market S.	S. S	Siller P.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 20587 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year SUGGS GAYTHEL 6:20 PM 20 2008 JUNE 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death JOHNS HOPKING BAYVIEW MEDICAL CENTER BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🕅 F 236 42 2942 78 May 18,1930 West Virginia Usual Residence of Decedent 10c. City. Town or Location 10h. County 10d. Inside City Limits 1 XYes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 620 Tolna Street USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert M. Jones Hattie Mashburn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth E. Suggs (Husband) 620 Tolna St. Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/23/2008 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. W. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARREST HOURS disease or condition resulting in death) Due to (or as a consequence of): MYOCARDIAL DAYS INFARCTION Sequentially list conditions, Due to (or se a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CURONARY ARTERY DISEASE Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Director

Funeral

2

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Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examinational be notified and once.

Baltimore, Maryland 21215-0036

the Maryland

Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death. and burial-tran attending physician for use as the buria ed by the detached i signed by t peen has certificate director, this funeral After 1

P.O. Box 68760,

Division of Vital Records,

Examiner

nours after death neral Director: / filled in by the f 24 hours a To the within 2.

State Registrar

Physician/Medical IF FEMALE: Completed Be 1 Yes 2 No 27. Manner of Death Certification: 1 Natural 2 Accident 3 Suicide 4 🔲 Homicide 29a. Certifier Medical

29b. Signature and title of pertifier MO.

5 Pending

investigation

6 ☐ Could not be

medical resident

28a. Date of Injury (Month, Day, Year)

and manner stated

1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number RESDO

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

JUNE 20, 2008

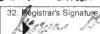
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EMMANUEL GOROSPE, MO JUHNS HOPFINS BAYMEN MEDICAL CENTER/4940 EASTERN AVE, BALTIMORE, MO 21224

31. Date filed (Month, Day, Year)

(Check only

2008 JUN 25





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First_Middle, Last) Month **Physician** 9:20 AM 2008 JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Hame (If not institution, give street and number) Examiner etemore 8. Date of Birth Month, Day, If Under 1 Year | If Under 24 Hrs. Social Security Number last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 213-18-341 1 M 2 F Director Usual Residence of Deceden filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at Yes 2 No more Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō UDIA 21 "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Never Married 2☐ Married 1 ☐ Yes 2 No 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than " any injury or other traumatic event, the Mea one. Improv Elementary/Secondary (0-12) Improve 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 nepher 212 710 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -68 3 Signature of Funeral Service Licenses Nancy M. Wallace P td1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause / inal disease or cond it in resulting in death **Physician** to (or as a cons quence of): /Medical Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed perference burial-trar and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregn 3 Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records. ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ 100 page 2 autopsy perform certificate Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manne of Death After Attending Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 - N°C 22. Registrar's Signature

Registrar DHMH 17 Rev 1/200

State

1 Mangelters 1 (Month, Day, Year) 1 UN 25 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Beatrice Barker 2008 7:20a/Medical June 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carrol1 Carroll Hospice Dove House Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min Months 1 □ M 2 👽 F 217-24-4970 82 Director June 8 1926 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location rai", or items 23a or 28a-f show MD Carrol1 Director Sykesville 1 ☐Yes 27 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? les 1 and 2 should be filed within 72 hours after death with of Health and Mertal Hygiene. If item 27 15 marked other than "natural", or Items 23a or rother traumatic event, It. World Examine in number. 4647 Bartholow Road 21784 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 □Yes 2 □No Specify: Completed by Specify: white 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic 12 homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard C. Barker Clara Gertrude Kelley ۴ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Evans (daughter) 4647 Bartholow Rd., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date = 5 permit. Pages
Department o
Important: If i
any injury or 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 6-26-08 Ellicott City, MD Good Shepherd Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Harge Haright P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bowel disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (u as) consequence of); Sequentially list conditions, if any, leading to immediate cause. Enser underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 □Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 2. No 1 ☐Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Dether (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Pages 1

State Registrar

Medical

3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signature and title of ce

6 Could not be

determined

4 Bo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

June 23rus, 2007

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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32. Registrar's Sig

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7:26 AM Walter Ambrose Simms Tune 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital N/A Baltimore If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **X** M 2□ F 216-20-0587 June 11, 1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d Inside City Limits 1 XYes 2 □ No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1260 Haverhill Rd. 21229 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 Pyes 2 No 194
If Yes, Give
Year or Dates: 194 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1944 1 Never Married 2 Married Specify: White 1 □ Yes 2 No Specify. 1946 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crown Petroleum Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Simms Cna Marchunas 19a. Informant's Name/Relationship (Type. Print)
Mark Simms, son Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3020 Lowery Rd, Huntingtown, MD. 20639 20b. Place of Disposition (Name of cemetery, crematory or other place)

Veteran's Cemetery of 06-23-08

Garrison Forest

Ambrose Funeral Home, Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Owings Mills, MD 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Rd. Arbutus, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration minutes disease or condition resulting in death) Duodenal Ulcer Perforation weeks Sequentially list conditions rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duodenal aler Bleed 4 WEEKS Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Year Day 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Trobably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner** death certificate be executed use as the burial-trai attending physician at for use as the burial

signed by the

After this certificate has been

To the Hospital or Attenct within 24 hours after death To the Funeral Director:

The law requires that

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

Funeral

Director

ייישיים יו וופייה על is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

of Health and Mental Hygiene.

Pages 1 and 2 should

permit.

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Baltimore,

Box 68760.

Division or Vital Records,

be filed within 72 hours after death with the Maryland

Examiner Physician/Medical Completed by Be Certification: To

Medical

State

IF FEMALE 23b. Was decedent pregnant in the past 12 months? TYPS 2 No. 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

28a. Date of Injury 5 ☐ Pending investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of (Month, Day Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

1 🗸 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ward Pint de Casta 29c. License number P19863 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Avenue Batimore MD Castro

31. Date filed (Month

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3UAM unnia Inamias W000 4a. Facility Name (# not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Season's Hospice Randallstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months 75 242-40-8102 13 32 NC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Baltimore Owings Mills 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 U.S.A. <u>166 Maybin Circle</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed M Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sinai Hospital <u>8th grade</u> Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sophia Allen James Gregory 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Beechwood Place, Irvington, NJ 07111 William M. Owens-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State

 X□ Burial
 2 □ Cremation
 3 □ Removal from State

 4 □ Donation
 5 □ Other (Specify)

 Memorial Park 6/24/08 Woodlawn, Md King 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 300 Wabash ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final luna can cev disease or condition resulting in death) Due to (or 🛊 a consequence of): encardial effusion Sequentially list conditions, it dry, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

attending physician and for use as the burial-transit

been signed by the should be detached

funeral director,

filled in by

within 24 hours a Hospital

After this

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be မ

th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mydical Exart with the retified at

of Health

item 27 other t

permit. Pages Department of Important: If it any injury or once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Completed by 25. Was case referred to medical Be

Physician/Medical Examiner certificate has be irector, page 2 st Certification: To s after dea... ral Director: Aft

or Attending Physician: The law requires that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? in the past 12 mor 9 Unknown

1 ☐ Yes /2 X No

29a, Certifiei (Check only 24a. Was an autopsy perform 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOSPICE 28d. Describe how injury occurred

1 🗌 Yes

1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Al Natural 2 🔲 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 1)60680 29d. Date signed (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EYIE HICKEWUTTO MUN SNCET REISTONDWN, EUTE MICHELION 750

31. Date filed (Month, Day, Year)

JUN 2 5 2008



State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPS#10a, perFH, C880, 6/25/08 WS
State of Maryland 7 Department of Health and Mental Hygiene Reg. No. 2008 20592 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day June 19, 2008 **Physician** Gwendolyn B. Tisdale 8:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hart Heritage Estates Street Harfard County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1 ☐ M 2 😿 F 213-32-1809 76 Maryland Director March 12, 1932 Usual Residence of Decedent with the Maryland 10a. State MD 10b. County

213-32-1809 Harford County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Street 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 r must be no United States 3708 Grier Nursery Road 21154 Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 'natural", or iten dical Examiner Black, White, etc. 1 Never Married 2 Married 10' 1 ☐ Yes 2 X No Specify: þ Specify White 3 Widowed 4 □ Divorced Completed er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 12 4 event, tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 Is marked or traumatic ever William Blchm Gwendolyn McDannel ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:3 Department of Health an Important; If item 27 Is any injury or other traugonce. Mr. Kevin Tisdale (Son) 32 Lake Drive, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel June 20, 2008 Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Bel Air 3 Newport Dr. Forest Hill, Maryland 21050 I tem of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementis **Physician** MEANS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): by Physician/Medical as, IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 1∐ Yes 2FTNo Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) ASS Sted Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 Yes 2 No မှ 6 ⊟Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No r death. 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide after Dire within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of confifier 35889 Ture 20, 2008

3

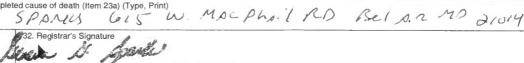
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year) **JUN 2 5 2008**

ALKRAD



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08-04700 Leroy Toney Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 20593 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day June 18, 2008 Leroy Toney 1343 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Country) Min. Days Hours Months Director 247-98-5856 1 xM 2 F May 11. 1956 Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10b. County 10c. City, Town or Location MD 1 XXYes 2 No Baltimore 28a-f show items 23a or 28a-f shorust be notified at once. hours after death with the Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country 2205 Roslyn Avenue Apt. 301 D Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 XX ever Married 2 Married Yes 2XX No African American 0 Baltimore, MD 21215-0036
permit. Pages I and 2 should be filted within 72 hours after
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", of
Injury or other traumatite event, the Medical Examiner.") Widowed 4 Divorced Yes, Give Yea Yes 2 XX No specify: ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed dunng most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 welder Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sammie Toney Be Fannie Mae Toney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy Toney, Jr. / Son 2205 Roslyn Avenue Apt. 301 D; Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Trinity Cemetery 06/27/2008 Baltimore, Maryland Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval each line. Between Onset and failure. List only one cause on /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ¬xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical X AMENDED the attending physician led for use as the burial -UNPENDED Iten#4b.perME.G880.6/25/08.WS Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) detached for 1 Yes 2 No 9 Unknown Unknown signed by the detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Yes 2 No 3 Probably 4 V Unknown ficate has been so, page 2 should h 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed? death? Yes Yes 2 V No 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other 4 examiner? Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes After 28b. Time of Injury 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 1 V Natural filled in by the fi Yes 2 No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined To the Funeral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 19, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD 31. Date filed (Month, Day, Year) Registrar's Signature State 2 Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

ORIGINAL

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE 22^{Day} FRANK TENNEY 2008 Рм 1:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3210 MIDFIELD ROAD BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) 09/05/1926 9. Birthplace (State or Foreign Months Days Hours Min. 213-20-1867 81 WV Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 MIDFIELD ROAD 21208 Completed by Funeral USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 Mayes 2 □ No WWII
If Yes, Give
Year or Dates: ARMY 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 X No Specify Specify: WHITE 3 Nidowed 4 □ Divorced ARMY 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR** F00D 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRED TENNEY MAMIE ဥ TENNEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA MAX / DAUGHTER 15 BRIAN DANIEL COURT, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW 06/24/2008 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Day 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Be Certification: To

sician and burial-transit The law requires that the death certificate be exec P.O. Box 68760. attending physician for use as the buria signed by the a Division of Vital Records, peen has certificate Hospital or Attending Physician: r this certificated rail director, p death.

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Funeral

Director

28a-f show

if than "natural", or items 23a or 28a-f sho

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, ITEM 2008.

Physician /Medical

Examiner

altimore, Maryland 21215-0036

after death Director: / d in by the f within 24 hours aft To the Funeral Di completely filled in

Medical

		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Death (CI	heck only one)
1 Yes 2 1 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	on (Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No	Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying F	hysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred a	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

16941

29d. Date signed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 (YON YOURS DY

31. Date filed (Month, Day, Year State **JUN 25** Registrar

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

2008 20595	2	0	0	8	2	0	5	9	5
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		1- For State Registrar			Certifica	ate of	Death					Reg. N	No.		
Physici		1. Decedent's Name (First, Middl	e,Last)			-				2	. Date of D		av Year		3. Time of Death
′ al Exami	iner	Cesar A.	Vallecill	0							Month June 22	, 200			0516 hrs
		4a. Facility Name (if not institution	n, give street and n	umber)		41	o. City, Towr	, or Lo	ocation of	f Death			4c. County o	f Death	
		6190 Tamar Drive					Columbi	а					Howard		
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birt	hday)	If Under 1				8. Date of	Birth(N	M/DD/YYYY)		hplace (State or
Director		219-55-1333	1 X X M 2 F		19	Yrs.	Months	Days	Hours	Min.	Feb.	27.	1989	Cou	n Honduras
		Usual Residence of Decedent	na -				<u> </u>								
any		10a. State 10b. County		100	. City, Town	or Location	n								10d. Inside City Limits
ž .	_	MD Howa:	rd		E-11	kridg									1 X Yes 2 No
Aaryland 28a-f show 1 <u>at once.</u>	cto	10e. Street and Number	Lu		1011	TITUG	10f. Zip Co	de				10q.	Citizen of Wh	at Cour	ntry?
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Ex miner must be notified at once.	Director						•		_					_	
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ith w	Funeral	4=1	12, Was De arried Armed F		r III U.S.		Decedent on s, specify Co					NO-	White		can Indian, Black,
or dez	Ful		1 Yes	2 X	No	4 77	v o 🗆	NI-	'6	**			Connection	r =1.	
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D 21215-0036 should be filed within 7 and Mental Hygiene. 'is marked other than atic event, the Medica	o Be	Antonio Valle 19a. Informant's Name/Relations			110	h Mailing	Addross /S	tract			Lilia		eron r, City or Tow	Ciato	Zin Code)
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MD and 2 sho alth and 2 is can 27 is		Norma L. Zero	n/Motner		20b. Place of						Date		e, MD Oc. Location -		
of He		1 Burial 2 Cremation	n 3 Removal f	from State		tory or oth		COIN	Story,		Date	-	oc. Location -	Oity Oi	Town, otate
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		4 Donation 5 Other S			West	Arun	del C	cem		6/3	0/200	8	Odento	n, I	MD
Balti permit. Departr Import		21 Signature of Funeral Service	Licensee	-10			ame and Add	iress o	f Facility	D	onald	son	Funer	al I	Home, P.A.
⊞ %♥₹≅		tanico	814C		M01103		3 Tall							207	
Physician		23a. Part L'Enter the disease, or failure. List only one cause		caused the	death. Do no	ot enter th	e mode of dy	/ing, s	uch as ca	ardiac or	respiratory	arrest,	shock, or hea	art	Approximate Interval Between Onset and
Medical ∠xaminer	ĺ	Immediate Cause (Final disease	I I al I - i	ies											Death
LAdilliller		or condition resulting in death)	Due to (or as	a conseque	ence of):										
		Sequentially list conditions,	b												
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a conseque	ence of):										
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):										
and and transit			d												
a a e	n/Medical	UNPENDED	AMENDED												
8760, ifficate be ex ng physician is the burial.	Mec.	IF FEMALE:	23c. If yes	, outcome o	f pregnancy								23d. Date of	deliver	y
687 ertific ding p	an/	23b. Was decedent pregnant in the past 12 months?	Live			2 Fet	al death	3	Ectopic	pregnan	су	- 1	Month	[Day Year
Box 687 re death certific the attending 1	Physicia	1 Yes 2 No 9 Uni		nant at time	of death ,	5 Oth	er (Specify)	_				- 1			
. D yethe de field f	⁵ hy	Part II. Other significant condit	9 Ulki		t not ropultin	a in the u	adorbána an	una ais	on in Do		23e Di	d toba	co use contri	bute to	the cause of death?
Records, P.O. Box 68. The law requires that the death certicate has been signed by the attendin page 2 should be detached for use a.	by I	Fart II. Other Significant Condit	ions contributing	to death bu	(HOL TESUILIT	ig in the u	idenying car	use giv	/eii iii Fa	II L 1.					pably 4 Unknown
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ord w req as bee												itopsy	l p	rior to	utopsy findings available completion of cause of
Reco	Completed											erforme es 2		teath?	es 2 No
of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should b	BeC	25. Was case referred to medica					26.F	Place o	of Death ((Check o	nly one)				
Vite ysicis his ce direc	9 B	examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient	2 ER/O	utpatient	3 DOA	70	ther ₄	Nursing	Home 5	Re	sidence 6	Othe	r: Scene
1 of Vi ding Physi After this funeral dir		27. Manner of Death	28a. Date	e of Injury	28b.	Time of In	jury 28c	Injury	at Work				injury occurr		
ion tendin eath. tor: A	ţi	1 Natural 5 Pend	anig	th Day Year) , 2008	050	5 hrs	1	Ye	es 2 🗸	No L	river au	to au	to collision	1	
(D = D = 5)	ica		stigation 28e. Pla	ce of Injury	- At home, fa	arm, stree	t, factory, off	ice bu	ilding, etc	c. 2	28f. Locatio	n (Stre	et and Numbe	er or Ru	ural Route Number, City
Divis	Certification:		Id not be 200.1 id rmined (Specify) Local	Street					6	or Town	n, State ar Driv	e) re, Columbia	a, MD	
Di the Hospital hin 24 hours of the Funeral		29a. Certifier	hysician: To the be		·	ath occurr	ed at the tim	e, dat	e and pla	ice, and o	fue to the c	ause(s) and manner	as stat	ed.
Di To the Hospital of within 24 hours a To the Funeral I completely filled	Medical	Chock only	miner: On the basis	of examina	_										
To wit	Me	29b. Signature and title of certifie	and manner	sidied.			29c. Li	cense	number			2	9d. Date sign	ed (Mo	nth, Day, Year)
		16 1 M	ce m				0	.C.N	l.E.			J	lune 22, 20	800	
0		30. Name and address of person			/Item 22a										
2		Tasha Greenberg MD				111	Penn Stre	et. F	Baltimo	re. MD	21201				
-	tate	31. Date filed (Month, Day, Year)		egistrar's S				, _							
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State of Maryland / Department of Health and Mental Hygiene 2008

			For State Registrar		State of	Marylan		artmen rtificat			and Me	ntal Hy	giene Reg. No.	2008	205	596
	Division		1. Decedent's Name (Firs	t, Middle, La	ast)							. Date of De Month		Year	3. Time of	
	Physicia /Medic				Frizz	ell	Dona	ld	W	illis	5	Month 06	19 ^{ay}	2008	8:40	a M
- Control	Examin		4a. Facility Name (If not in	nstitution, gi	ve street and numb	er)		4b. City,	Town, or	Location o	f Death		4c. (County of Death		
-			Future Ca	are	Nursing	Home		Bal	tim	ore						
	Funeral		5. Social Security Number	6.	Sex XXM 2□F		last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. 8	. Date of Bir (Month, Da	th ay, Year)	Cou	place (State ontry)	or Foreign
	Director		<u> 218-22-675</u>		XX. Z	7 9	TIS.					01-2	7-19	29	MD	
	and w		Usual Residence of Dece 10a, State 10b.	County		10c. Cit	ty, Town or Lo	cation							10d. Inside Ci	ity Limits
	f sho	ö	MD	N	Λ	B	altim	ore							1 X Yes	2 🗌 No
	the \7	Director	10e. Street and Number				<u> </u>	10f. Zip	Code			— Т	10a, Citiz	en of What Cou	intry?	
	with a or	ā			_					000					,	
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	iter	ᆵ	1 ☐ Never Married 2	☐ Married	Armed Force	es?				ın, Mexican	, Puerto Ri	fy Yes or No can, etc.)		Black, White,		
336	ours after death with the Marylan ral", or items 23a or 28a-f show Examiner must be notified at	þ	3 ☑ Widowed 4 □ □		1 Tyes 2 If Yes, Give Year or Date	es:		1 □Yes	2 X No	Specify:				Specify: B1	ack	
Õ	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show Inot Examiner must be motified at	Completed	15. C	ecedent's E	Education		16a. Dece	dent's Usua	al Occup	ation	-6		16b. Kin	nd of Business/li	ndustry	
215		ble	(Specify on:		rade completed) College (1-4	or 5+)	life.	DO NOT us	se retir e d	during most f)	or working					
21	filed within Hygiene. Ither than "	on	12th grade		na		S	teel	Wo	rker	_		Beth	Steel	Corp	•
p	other vent, II	Be (17. Father's Name (First,		it)							First, Middle	, Maiden S	Surname)		
<u>a</u>	4 2 5 5	To E	Edward Wil	lis						Mami	ie Ev	ans				_
Maryland 21215-0036	d 2 should be filed the and Mental Hygis 7 Is marked other traumatic event, III		19a. Informant's Name/R	elationship	(Type. Print)			-						Town, State, Z		
	70 to Po 40		Aleasea Sn	nith-	Grandda	ughte	r 46	07 P	en :	Lucy	Road	#B,	Bal	timore	, Md	2120
Baltimore,	Pages 1 and ment of Healt ant: If item 2 ury or other		20a. Method of Dispositio	n		20b. F	Place of Dispo cemetery, crer	sition (Nam	ne of ther plac	(e)	Dat	e	20c. Loc	cation - City or T	own, State	
Ē	Page tent c nt: If ry or		1 Burial 2 □ Cre 4 □ Donation 5 □ 0	mation 3 l Other <i>(Spe</i> c	□Removal from St ify)	ate I					6/2	7/08	Ow	ings M	ills	Md
äĦ	permit. Page Department (Important: If any injury or once.		21. Signature of Funeral			A Ga				ss of Facility	y Ma	arch	West	F/H		
ä	an me		- Shan	nan	Lhai	an	1	300	Wab	ash .				MD 2	1215	
			23a. Part 1. Enter the dis	ease, or cor	mplications that cau	sed the deat									Approximat Interval Bet	.e
	Physician		shock, or heart failu Immediate Cause (Final	ire. List only		TEW	CHI	CAR	010	M70P	AT 14 -	1		1	Onset and	Death
1	/Medical		disease or condition resulting in death)		- a.	as a conseq		2711	2101	1701		/				
N.	Examiner			- 1			ENSIS	N								
		er	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	is, ite	D	as a conseq										
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\.	e be executed sician and burial-transit	Examiner	resulting in death) Last		,	as a conseq										
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.89	The law requires that the death certificate ite has been signed by the attending phys age 2 should be detached for use as the I															
Вох	andin use	by Physician/Med	IF FEMALE: 23b. Was decedent pregr	nant	23c. If yes, outco	me of pregnath		∃Ectopic p	wo an an a	.,			2	3d. Date of deli	-	
œ	deatl e atte d for	icia	in the past 12 month 1 ☐ Yes 2 ☐ No	ns?	4 ☐ Pregna	nt at time of		Other (sp		у				Month	Day	Year
P.0	t the by th ache	hys	9 Unknown		9 Unknov	vn						1				
π.	 requires that the dispersion is been signed by the should be detached 	y P	Part II. Other significant			th but not res	ulting in the u	nderlying c	ause giv	en in Part I.		23e. Did	tobacco us	se contribute to	the cause of o	death?
ğ	quire en sig uld b	be pe	HYPERL	-18106	MIA							10	Yes 2]No 3∏ Pro	obably 4	Unknown
ပ္ပ	s bee	Completed	GOUT									24a. Was		24b. Were au	opsy findings	available
Be	he law te has age 2 a	EC.											ormed?	death?	ompletion of o	ause of
tal			25. Was case referred to	medical						26 Place	of Death /	Check only	2⊠No	1 L Yes	2 □No	
5	/sicla	o Be	examiner? 1 ☐ Yes 2 ☑ No		Hospital:	natient 2] ER/Outpatie	nt 3 🗆 DE	Oth	-				Other (Spec	ifv)	
Division of Vital Records,	Attending Physician: It death. ector: After this certifice by the funeral director, p	n: T	27. Manner of Death		28a. Date of	Injury	28b. Time o		28c. Injur Worl			d. Describe				
o	th. Fun	ıţi	1 Natural 5 ☐ 2 Accident	Pending investigation	,	Day, Year)	Injury	м		kr Yes 2 ∐l	No					
/isi	Attendi r death. ector: A by the fu	iţics	3 ☐ Suicide 6 ☐	Could not	28e. Place o	f Injury - At h	ome, farm, str	eet, factory	, office		28	f. Location	(Street and	d Number or Ru	ral Route Nun	nber,
ă	after after din t	Certification: To	4 ☐ Homicide		building	, etc. <i>(Speci</i>	TY)					City or 10	wn, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	a C			Physician: To the b											
	e Ho 1 24 h e Fui letely	Medical	(Check only 2 ne)	Medical Exa	aminer; On the bas and manne		ation and/or ir	vestigation	ı, in my c	ppinion, dea	th occurred	d at the time	, date and	place, and due	to the cause(ŝ)
	Nithir Somp	Me	29b. Signature and title o	f certifier	-					e number				e signed (Month	-	
					AT	TEND	724		Doo	5694	8		JUN	E 23	3008	>
	211		30. Name and address of	person who										, -		
	J.		30. Name and address of Amel Amel Amel Amel Amel Amel Amel Amel	W : CV	DA 300 A	RAMI	PUTC	= Fu	INF	311	BALT	mont	NO	2121	+	
	Sta	tę	31. Date filed (Month, Da	y, Year)	32 Re	gistrar's Signa	ature	- 40 -		1						
	Registr	ar	JUN	252	UUO John	ALLOW S	Or Soft	Sec.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2008 10:50 AM JEFFREY WALTEMYER JUNE 20

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Birthplace (State or Foreign Country)

N/A

Physician /Medical Examiner

for State Registrar

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

ineral rector		5. Social Security Number 208 38 309	6. Se	7. Ag	e (In yrs. last I	birthday) Yrs.	If Under 1 Ye Months Day		Min.	Date of Bir (Month, Da	nth ay, Year)	Co	thplace (S untry) PA	tate or Foreign
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8a-f sh tified a	Director		York		Yor	k								Yes 2 No
a or 2 be no		10e. Street and Number		- 3			10f. Zip-Cod				-	tizen of What Co USA	ountry?	
s 23 nust	Funeral	2255 Esben	shade	Road 12. Was Decedent 8	Ever in II S	12 1	Jac Decedent (1740		ly Yes or No)-	14. Race - Ame	rican Indi	an.
er n	١	11. Marital Status 1 ☐ Never Married 2	(C)Mousiad	Armed Forces?	No.	10. H	vas Decedent o Yes, specify C	uban, Mexica	n, Puerto Ric	an, etc.)		Black, Whit	e, etc.	
al", or xamin	þ	3 Widowed 4 Di		If Yes, Give Year or Dates:	NO	1	☐ Yes 2☐	lo Specify	r: _			Specify:	Whit	.e
"natura edical E	Completed	(Specify ont)		de completed)		(Give I	ent's Usual Oc kind of work do OO NOT use ret	ne during mo	st of working		16b. F	Kind of Business		
the M	Com	Elementary/Secondary		College (1-4 or 5	,+)	Qua.	lity C		l Ins				se D	epartme
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name <i>(First, M</i> Clyde L		temyer,	Sr.				th E.			n sumame)		
ls mai aumat		19a. Informant's Name/Re			1.0							or Town, State,		
n 27 Ier tr		Catherine		emyer								PA 174		
t: If iter y or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crer 4 ☐ Donation 5 ☐ 0	mation 3 🗌		ceme	etery, cren	sition (Name of natory or other 7 10ur	olace) ¦	6/26			ocation - City or \mathtt{rk} , $$	lown, St	ate
mportan ny Injur nce,		21. Signature of Funeral S			•	52	Name and Ac	dress of Faci	© Cha	tman	-Ha: d Ba	rris F	uner	al Home
= 00		z3a. Part 1. Inter the dise	y-	fractions that assessed	Litho dooth D								Appr	oximate
	-	shock, or heart failure	e List only	one cause on each lin	i the death. D	o not ent	si tile illoue oi	uying, suar a	is cardiac or	respiratory	arrest,		Inter	ral Between t and Death
sician		Immediate Cause (Final disease or condition	' _	a CARDI		ARRE	51							IIM.
edical miner		resulting in death)		Due to (or as				_	_				١, .	
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phys s the	edi			u							-			
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d by detac	유	Part II. Other significant	conditions	ontributing to death b	out not resulting	ng in the ι	nderlying caus	e given in Pa	rt I.	23e. Did	tobacco	use contribute	to the cau	se of death?
signe Id be	d b	PANCRE	ATI	TIS						1 🗆	Yes :	2 ∭ No 3□F	robably	4 🗌 Unknown
shoul	ete									24a. Was	s an			idings available
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cate		25. Was case referred to r	medical					26 Plan	ce of Death (0			lo 1 □ Ye	5 2 🗆 1	
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al Dire		4 Homicide		building, et				- time data	and alone on	-			as stated	1
To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 shou	Medical	29a. Certifier 1 1 2 (check only 2 1 N	Vertifying Pr	nysician: To the best of miner: On the basis of manner st	f examination	and/or in	restigation, in r	ny opinion, d	eath occurred	d at the time	e, date a	nd place, and d	ue to the	cause(s)
To th	Me	29b. Signature and title of	t certifier	()				ense number			29d. D	ate signed (Mor	ith, Day, Y	ear)
		NA		tu)				5-00	20		J	ONE	20,	2008
15		30. Name and address of VINCENT I		L M.D. T	HE JOH	WS H	OPKINS	HOSPITA	600 N	orth W	olfe S	St, Baltim	ore, I	MD, 21287
	ate	31. Date filed (Month, Day	y, Year)	32 Registra	ar's Signature	A.	relle y							
	rar	** * * * *	2 5 20	138 De 100 100 100 100 100 100 100 100 100 10	1 SA	100	Section .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Caismer Joseph Wisomierski 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death harles Plata If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Year 1 X M 2 ☐ F Months Days Hours Min. Maryland 84 216 12 8911 11/02/1923 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 □ Yes 2 No Anne Arundel Pasadena Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 232 Bar Harbor Road 21122 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steamship Trade Longshoreman 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Wisomierski Mary Gralewski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Curci / Daughter 232 Bar Harbor Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State MD State Veteran Cem. 06/25/2008 Crownsville, Maryland 4 Donation 5 Dother (Specify) ature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 amerous Part 1. Enter the dise or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failine. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final as disease or condition resulting in death) to (or as a consequence of the Sequentially list conditions, It any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 20 No 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **2**No 1 2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Examiner be executed sician and burial-trans Box 68760, law requires that the death certificate the attending pl Ö ed by the detached signed I Division of Vital Records, page 2 should Physician: The certificate this

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

3 Suicide

29a. Certifier

4 🗌 Homicide

(Check only one)

29b. Signature and title of certifier

any ir

Physician

/Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Important Exantment traumatic event, Important Exantment traumatic and Importantment traumatic and Importantment Importantmen

Baltimore, Maryland 21215-0036

Omierski,

funeral director, After Hospital or Attending death. within 24 hours after deatl To the Funeral Director; filled in by the completely

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) entennia tmir 31. Date filed (Month, Day, Year)

Could not be determined

Street Suite Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** OSEPH UNE 18 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ARBOR HOSPI IMORE N/A TAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** MaryTand 1 X M 2 □ F 54 Yrs. 05/01/1954 Director 216 62 6557 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 Yes 2 No be notified N/A Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21225 U.S.A. 3711 - 8th Street items 23a by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) New England Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monee. 9th Forklift Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Wain Helen Hood ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 3711 - 8th Street Geneva Wain / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 06/23/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signalate of Fund ral Service Licens 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the geath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Anodic **Physician** en cephalofath 7-days disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examinet the Hospital or Attending Physician: The law requires that the death certificate be execute physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760s Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No r death. 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar alfawossen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JEGAYE HU

31. Date filed (Month, Day, Year) 31. Da

JUNE 18,2008

3001 SHENOUEN STroot, 21225,100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20600 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0910 PM JUNE 2008 18 Gertrude Irene Watts /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTEMORF HOCP25AL AGNES 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 250XF Aug. 21, 1939 214-38-1734 68 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at trayes 2 □ No Baltimore. Reisterstown Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21136 USA 7 Coliston Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐ Yes 21√21No Specify SpecifAfrican American ģ 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Credit Union of Baltimore 12 receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Reed Theophilus Watts Margaret Murray traumatic ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S 2 Cedar Tree Court Apt. K; Cockeysville, Maryland 21030 Karen Watts / Daughter 27 permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1KOkBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gardens 06/25/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service License 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBRO VASCULAR ACCEDENT 27 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the attending p for use as t 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ned by the a 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RENAL FAILURG. CONGELTEVE HEART Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ACRIAL page 2 autopsy performed' 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No DLARETES MELLIAUS 147 PERTENSEON 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: stely filled in by the 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

of Vital Records, GERTRUDE Division Hospital or Attending hours after death. 24 1 the 0

o

Maryland 21215-0036

Baltimore,

State Registrar

RADEREDOR 31. Date filed (Month, Day, Year)

St AGNES

29c. License number 21227

BAUTEMARE, OND.

29d. Date signed (Month, Day, Year)

JUNE 2008 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

HOZPETAY

2. Registrar's Signature

29b. Signature and title of certifier

SRIDHAR

RONNie Ware, Jr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04687 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 2008 20601 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 17, 2008 2318 hrs Medical Examiner are 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University Hospital 9. Birthplace (State or Foreign 8. Date of Birth (MM/DD/YYYY If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours -4-1989 Director 216-25-1786 1 X M Yrs 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any lob. County 1 Yes 2 No s 23a or 28a-f show e notified at once. Md. hmore N permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 31a or 32e. f. also. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21213 U.S. A. 3110 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) If item 27 is marked other than "natural", or items her traumatic event, the Medical Examiner must be Armed Forces? 1 V Never Married 2 2 X No Yes Specify: Black 2 No specify: If Yes, Give Year Yes Widowed Divorced ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 12 parer 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Ware 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Kenyon O. Ware 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) 1 🔀 Burial 2 Cremation 3 Removal from State Donation 5 Other Specify 22 Name and Address of Facility

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1701 Mc Culleh ature of Funeral Service License Ba /h. a 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Physician/Medical AMENDED UNPENDED P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Day Year Month 23b. Was decedent pregnant in the Fetal death Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 ✓ No 3 Probably 4 Unknown þ Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed' ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ examiner? Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 2 No 2 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Jun 17, 2008 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: Subject shot 2233 hrs 1 _ 1 Yes 2 V No Natural Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 1837 Clifton Avenue, Baltimore, MD 3 Suicide determined (Specify) Restaurant 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 18, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Drilvin 17 Rev 1/2001 OCME 2006

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ORIGINAL

		1 - For State Registrar	State of	of Marylan				ealth a Death	ınd M		giene Reg. No	00	8	200	502
		Decedent's Name (First, Middle, Las	t)							2. Date of Dea			'ear	3. Time o	f Death
Physic		George A. Aydin	ian							Month June	9, Day	008	еаг	8:10) a ^M
/Medi Exami		4a. Facility Name (If not institution, give	street and nu	ımber)		4b. City,	Town, or	Location o	f Death		4c. (county of	Death		
		Montgomery Gener	al Hos	pital		0	lney				Mo	ntgo			
Funeral		Social Security Number 6. Security Number		7. Age (In yrs.		If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	y, Year)		Birthpl Coun	ace (State ry)	or Foreign
Director		100-12-5669	3 M 2□ F		84rs.					Aug. 5	, 19	23	Nev	York	
p s		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	ty, Town or Lo	cation							10	d. Inside C	ity Limits
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urs a	b	3 Widowed 4 Divorced	If Yes, G Year or	ive Dates: 1943	-46	1 🗌 Yes	2LXNo	Specify:				Specify:	Whi	:e	
d within 72 hours at giene. er than "natural", or the Medical Eval.	Completed	15. Decedent's Ed (Specify only highest gra	ucation	1	16a. Dece	dent's Usu	al Occup	ation during most	t of worki	ng	16b. Kin	d of Bus	iness/Ind	ustry	
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C/ 42 m		19a. Informant's Name/Relationship (1) Catherine C. Ayo		Wife	196. Mailii	ng Addres: 6806	Hoff	man M	lanor	Anoute Number Drive	, Sil	.ver	Spr:	ing, I	MD 209
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mit. Pages 1 a partment of Hes portent: If item y injury or others.		1 😾 Burial 2 □ Cremation 3 □		State	cemetery, crei	matory or o	other place			e 17,			•		v 7 -
permit. Pages 1 Department of H Importent: If itel any injury or ott		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signatore of Funeral Service Licen		Ga	te of			ss of Facilit		8008	Sil	.ver	spr.	ing,	Maryla
Per		21. Signature of Yulielan Service Licent	000			Franc	ie J	[CO]	line	Funera	al Ho	me .	Inc.	ac M	D 2090
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建		shock, or heart failure. List brily	pne cause on	each line.										On set and	Death diate
Physician /Medical		disease or condition resulting in death)	4.	Myocar		nfaro	tion	1						Timile	ulate
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eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	1 🗀 Live	utcome of pregn birth 2 Fet	al death 3	⊒Ectopic p		/			• 2	3d. Date Mon		Day	Year
	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9⊟Unk	gnant at time of o nown	death 5	Other (s	oecity)								
The law requires that the tite has been signed by the bage 2 should be detached.		Part II. Other significant conditions of	ontributing to	death but not re:	sulting in the u	ınderivina	cause giv	en in Part I		23e. Did t	obacco u	se contri	bute to the	ne cause of	death?
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lor Attending Physicien: The lavaler death. Director: After this certificate has in by the funeral director, page 2.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2€XNo	Hospital:	Inpatient 2] ER/Outpatie	nt 3 D	OA Oth			n <i>(Check only o</i> me 5 ☐ Resi		Othe	t (Specil	v)	<u></u>
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s after al Directory	Certification:	4 El Honnolde	Bull	ding, etc. (Spec	'''\$'					2, 3, .0					
To the Hospitel or A within 24 hours after To the Funeral Direct completely filled in b.		29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the	ne best of my kn	nowledge, deal	th occurred	at the tir	me, date ar	nd place,	and due to the	cause(s)	and mar	ner as s	tated.	(s)
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To the comp	Σ	29b. Signature and title of certifier				29		e number	5			e signed ne 9		Day, Year)	
1		Hour	7												
1701		30. Name and address of person who	completed ca	use of death (Ite 109 Prir	em 23a) (Type	Print)	Drive	0 07	nev	MD 208	32				
		Philip Henjum, M	1 100			гттБ	DE IV	e, OI	ney,	FID 200					
Si	ate	31. Date filed (Month, Day, Year)	67	Registrar's Sign	lature And	salf 3									

		Please	State of Maryland / Department	artment of Health and M	Mental Hygi	ene	
		Registrar	Ce	rtificate of Death		3	
Physici /Medio		1. Decedent's Name (First, Middle, La Nathan	st) James Atwood		2. Date of Death Month June 9	Day Year	
Examin		a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
	e	National Luther	an Home	Rockville		Montgomery	
Funeral		5. Social Security Number 6. S	, , ,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birthplace (State or Foreign Country)	
Director		391-22-5143	12XM 2□F 82 Yrs.	World's Day's Hours Will.	Nov. 12		
ğ		Usual Residence of Decedent					
ylar how		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits	
Ma -1-	io	Maryland	Montgomery Rock	kville		1 ☐ Yes 2 ☐ X No	
r 284	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?	
5-0036 72 hours after death with the Maryland natural; or Iteme 23a or 28s-1 ehow dieal Examiant must be motified at	0	9701 Veirs Driv	/e	20850		USA	
Jeath The 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,	
te ite	F.	1 ☐ Never Married 2 ☐ Marned	1 MYes 2 □ No		o Rican, etc.)	Black, White, etc.	
II, ou	β	3 Midowed 4 □ Divorced	If Yes, Give Year or Dates: 1945-67	1 ☐ Yes 2 ☑ No Specify:		Specify: White	
- Po	ed	15. Decedent's E		dent's Usual Occupation		6b. Kind of Business/Industry	
15 in 72	iet	(Specify only highest gr	ade completed) (Give	kind of work done during most of wor DO NOT use retired)	king		
within sne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Media Communicatio	na Spadi	Military/ alist Civil Service	
D Hand	ŏ	17. Father's Name (First, Middle, Last			ne (First, Middle, M		
ntal be	Be	Milton Baldwin	,	_		,	
Ya bould Men Men Marke	2			Grace I		0) 7 0 4 7 0 4	
is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Exam part must be confilled at		19a. Informant's Name/Relationship	Type, Print) 196. Maili	ng Address (Street and Number or Ru	rai Houte Number,	City or Town, State, Zip Code)	
and and Balth in 27		Anita Harris/Da		356 County Road, #	302, Nac	ogo Joches , TX 75961 Oc. Location - City of Town, State	
SS 1		20a. Method of Disposition 1 ☐ Burial 2 ★★ remation 3 ☐	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place)	June 10	20c. Location - City of Town, State	
Page Page Intr. If		4 □ Donation 5 □ Other (Speci	(y) Metropo	olitan Crematory	2008	Alexandria, Virginia	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or any injury or other traumatic event, the Marked Expandons.		21. Signature of Funeral Service Lice		Name and Address of Facility of Tancis J. Collins	Funanal		
Ball Permi Depar Impo) (databas)				lver Spring, MD 20901	
		23a. Part1. Enter the disease, or com	prications that caused the death. Do not en			st. Approximate	
1 - 1 m		shock, or heart failure. List only	one cause on each line.		,	Interval Between Onset and Death	
Physician		Immediate Cause (Final disease or condition resulting in death) PULNOUMY EMBOLISM Due to (or as a consequence of):					
/Medical Examiner							
Examine		Supportiantly list sonditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):					
/ D =	ner						
60, to be executed sician and burial-transit	Examiner	that initiated events	C.				
60, be exe	EX	resulting in death) Last	Due to (or as a consequence of):				
760 e be sicia e bur	cai		d.				
Vision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificate r death. ector: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	edi						
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Division of Vital Records, to a Attanding Physician: The law requires thatler cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be query.		Partil. Other signmeant contamons	contributing to death but not resulting in the c	andenying cause given in Fait i.			
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Division of Vital Records, F To the Hospital or Attending Physician: The law requires tha within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	S						
ospl hou uner ly fill	la	29a. Certifier (Check only (Check only a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
ne H	Medical	one)	and manner stated.	ivestigation, in my opinion, death occu	nied at the time, of	are and place, and due to the cause(s)	
Nithiin To th	ž	29b. Signature and title of certifier	44	29c. License number		9d. Date signed (Month, Day, Year)	
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		UATH AWTHOM	970) UEIAS DRIV		no:	20850	
(a) (b) (c)		31. Date filed (Month, Day, Year)		,			
Sta Registr		JUN 1120	32 Registrar's Signature	34(2)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** Michael Anderson 8:59p June 8, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**™**M 2□ F 213-56-3538 58 13, May 1950 Washington, Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It a Medical Examinat must be notified at ury or other traumatic event, It a Medical Examinat must be notified at 1 ☐ Yes 2 🗷 No Director Maryland Montgomery Olnev 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19637 Islander Street 20832 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Space and Aeronautics/ College (1-4or 5+) Elementary/Secondary (0-12) Information Technology Computers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patricia Jacob Donald Eric Anderson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19637 Islander Street, Olney, MD 20832 Diane M. Anderson/Wife Department of Health a Important: If item 27 is any Injury or other tra once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition June 1 2008 1 ☐ Burial 2 ☐ *Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Prancis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3 Onsat and Death Immediate Cause (Final Myocardial **Physician** disease or condition resulting in death) /Medical s a consequence of): **Examiner** Sequentially list conditions day, learny to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conservence of Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) s been signed by the should be detached a Tilinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has b irector, page 2 sh autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 X ER/Outpatient 3 □ DOA 1 ☐ Inpatient Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

To the Hospital or within 24 hours after death.

To the Funeral Director: Aft

Lotaly filled in by the fur

State

Medical

s of person the completed cause of death (Item 23a) (Type, Print) kee, MD 15225 Shady Grove Road, Rockville, MD 20853 Yackee, 31. Date filed (Month, Day, Year)

JUN

29b. Signature and title of certifier

(Check only one)

32 Registrar's Signature

2008

W

29c. License number

D35261

29d. Date signed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygien 2008 20605 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:00 P M 5 2008 Emily June Blaney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Genesis Spa Creek Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 10/20/1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2□√F 85 036 14 2434 Yrs. Rhode Island Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State •how Pages 1 and 2 should be filed within 72 hours after death with the Maryla nand Mantal Hygiene.
Then to Health and Mantal Hygiene.
The same of the marked other than "natural", or flems 23a or 28a-1 show and it is the marked other than "natural", or flems 2a or 28a-1 show try or other freumatic event, in the disciplinal at 1∏Yes 2∏No Director MD Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 323 Riding Ridge Rd 21403 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🟋 No þ Specify: XX Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٥ Peter Del Pozzo Angelina DiSanto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harold E. Blaney, Jr. 323 Riding Ridge Rd/Annapolis MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny Injury or ot Metropolitan Crematory 6/7/08 t ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Advent Funeral & Cremation Services Annapolis MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 200 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to intradulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a ponsequence off-Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 | Fetal death Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA Other: 1 ☐ Yes 2 ☐ ¥o Certification: To Nursing Home 5 Residence 6 Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No I Director: A investigation death. 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Hospital tilled 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Ę 29b. Signature and title of G rtiff Disonh Irine Chiland 21619 completed cause of death (Item 23a) (Type Print) 30. Name and address of person w 2-108 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6/7/2008 5:20an Daniel Edward Baran /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Crownsville Anne Arundel 1100 Opaca Ct. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7 Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 6 Sex Days Hours Min. 1 1 M 2 □ F 208-36-3810 7/26/1945 62 PA Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes %TNo MDCrownsville Anne Arundel Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1100 Opaca Ct. 21032 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Edward Baran <u>Lucia Kitlinski</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anna Baran 1100 Opaca Ct. Crownsville, MD 21032 Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery 6/12/2008 | Nanticoke, PA 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Euneral Service Licensee Data Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the diseate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Imphoma Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

Funeral

Director

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permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy,
Important: If item 27 is marked othe
any Injury or other traumatic event,
once.

e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Box 68760.

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Division or Vital Records,

and physician a as attending p for use as signed by the a been si should I page 2 s this certificate

ner Examir Physician/Medical þ Completed Be 2 Certification: Medical

the death certificate be executed The law requires that To the Hospital or Attending Physician: Director: After that in by the funeral death. 24 hours after filled To the Funeral

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 **N**O 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 2 Accident 5 | Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide TC CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

JUN 1 0 2008

Stuart



State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 JUNE **Physician** CLIFFORD BUTTRAM 6 F. 4:15 A^{M} Sr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Rockville MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Oct., 20 9. Birthplace (State or Foreign Funeral Months Days Hours Min 1 X M 2 T F Director 409-56-9418 70 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examination to other traumatic events. Director MD 1 ☐ Yes 2 ☐ No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 U.S.A. Funeral 8320 Colesville Rd Bld3-109 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No 1961- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Nes 2 No 196 If Yes, Give Year or Dates: 1963 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Walter Reed Elementary/Secondary (0-12) College (1-4or 5+) Position Classifier Medical Center 6yrs 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Alberta Stokes Albert C. Buttram ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City of Town State Sin Code) 19a, Informant's Name/Relationship (Type. Print) Betty Buttram- Wife 8320 Colesville Rd Bld 3-109 MD, 20910 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from 6/12/08 Suitland, MD 4 ☐ Denation 5 ☐ Other (Specify) Memorial ncoln 22. Name and Address of Facility Snowden Funeral Home, gnatur of Funeral Service Licenses 246 N. Washington St Rockville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fairly. List only one cause on each line. Approximate Interval Between Onset and Death 10 YRS Immediate Cause (Fixed disease or condition resulting in death) **Physician** ALZHEIMERS DEMENTIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Unverlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) the attending physician ned for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown signed by the best of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen Hemochromatosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 □Yes 2 🔀 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Special State) 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 D45533 June 9, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Snow, MD 15001 Dufief Mill Rd North Potomac, MD 20878 31. Date filed (Month, Day, Year) 2. Registrar's Signature JUN 1 1 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 20608 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 June 6, 6:45 P M Sylvia M. Brown /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1131 University Blvd. W. #222 Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 ☐ M 2 🗓 F 85 **Director** 260-18-2862 July 8, 1922 Georgia Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examirer inust be rediffed at Maryland Montgomery Silver Spring 1X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 may injury or other traumatic event, the Medical Examinational Examination once. 20902 1131 University Blvd. W. #222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White Completed by 1 ☐Yes 2X No Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jenny Rosen Nathan Mogul ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21214 5613 Fair Oaks Avenue, Baltimore, Maryland Lawrence Brown, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 X Removal from State Mt. Hebron Cemetery 06/11/2008 Flushing, New York 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc. of Funeral Service Licensee 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4 MONTHS CVA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HTN 10 YEARS Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit BRADYCARDIA - PACEMAKER 4 MONTHS Due to (or as a consequence of): P.O. Box 68760, HYPERCHOLESTEROLEMIA 10 YEARS Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🛣 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ HYPOTHYROIDISM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4√€ Unknown I or Attending Physician: The law requir after death. Director: After this certificate has been s J in by the funeral director, page 2 should Completed OSTEOPENIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🔼 No 1 ☐ Yes 2 ☐ No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) X Yes 2 □ No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1X Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral Ecompletely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAURIE M. CRAIN MD 10810 CONNECTICUT AVENUE KENSINGTON MD 20895 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 11 2008 Registrar JUN

			Please 7	Type or Print in Black State of Maryland / De			-	•	
			1 - For State Registrar		Certificate of		Reg.		20609
6	(1) H		Decedent's Name (First, Middle, Last,)	.	2	. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	_	Marie Paul:	ina Bratt			June 5	,2008	10:00p M
)	Examin	er	4a. Facility Name (If not institution, give 11125 Nicholas Dr	ive	Sil	or Location of Death ver Spring If Under 24 Hrs. 8		4c. County of Death Montgo	mery
	Funeral Director		5. Social Security Number 577-12-6300 Usual Residence of Decedent	x	Months Davs	Hours Min.	Date of Birth (Month, Day, Ye) Dec 13,	1909 Ge	nplace (State or Foreign intry) rmany
	/aryland f show ed at	or	10a. State 10b. County	10c. City, Town of Silve	or Location or Spring				10d. Inside City Limits 1 ☐ Yes 2 X No
	the N 28a-	Directo	10e. Street and Number	gomery	10f. Zip Code		10g.	Citizen of What Co	untry?
	3a or	at Di	11125 Nicholas D	rive	20	902		USA	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I	Hispanic Origin? (Speci pan, Mexican, Puerto Ri	fy Yes or No-	14. Race - Amer Black, White	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 □ Yes 2 No		ouri, etc./	Specify: Wh	
,	72 h "natu dical	etec	15. Decedent's Edu (Specify only highest grad	le completed) (Decedent's Usual Occu Give kind of work done	during most of working	16b	. Kind of Business/I	ndustry
7	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire Homemaker	(a)		Own Home	
N	filed v Hygie other i	ပ္ပို	17. Father's Name (First, Middle, Last)		Homemaker	18. Mother's Name (
yland	ld be lental ked o	To Be	Unknown Steimle			Unknow	n		
Mar	s 1 and 2 should be filed within 72 hou Fleath and Mental Hyglene. Item 27 Is marked other than "natura other traumatic event, the Medical E.		19a. Informant's Name/Relationship (7) Beverly A. Anders		,	t and Number or Rural i w York Avei			on, DC 2000
altimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State Removal from State	Disposition (Name of crematory or other place oolitan Cre	matory	na 10	Location - City or Alexandri	Town, State a, Virginia
Balt	permit. Page Department of Important: If any injury or once.		21. Signatur of Funeral Service Licens		4	J. Collins	Funeral		• ng, MD 2090
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	cations that caused the death. Do no					Approximate Interval Between
	Physician /Medical		snock, or near tailure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardi	al Infarct				Onset and Death 4 hours
# 	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Atheroscleroti		sease			10 years
,	executed n and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of	·):				
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O. Box	ne death certificate be the attending physicia hed for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	су		23d. Date of del Month	ivery Day Year
7.	es that the de gned by the a be detached to	by Ph	Part II. Other significant conditions co	entributing to death but not resulting in	the underlying cause gi	ven in Part I.			the cause of death?
ord	w requires to been signer should be						1 Yes		obably 4 □Unknown
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Vital	clan: ertifica	Be	25. Was case referred to medical examiner?		Lou	26. Place of Death			
0	chysic this c	ျ	I les Z No	Hospital: 1 Inpatient 2 ER/Out	patient 3 DOA Ot	her: 4 Nursing Home			cify)
Division (tending F eath. tor: After the funer	Certification:	27. Manner of Death 1		jury Wo]Yes 2□No	3d. Describe how		and Flaute Mumber
2	oital or Al urs after d ral Direc		4 ☐ Homicide determined	28e. Place of injury - At home, farr building, etc. (Specify)			City or Town, S		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	(Check only 2 Medical Exam	vsician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	or investigation, in my	opinion, death occurre	d at the time, date	and place, and due	e to the cause(s)
•	/ ○	2	29b. Signature and title of certifier	wsfork my	29c. Licen	D09748	29d.	June 6,	2008
			30. Name and address of person who calan Weinstock, I		ype, Print) La Avenue,	#105, Silv	er Sprin	g, MD 209	02

State Registrar 31. Date filed (Month, Day, Year)



			for State Registrar	State o	f Maryland /	-	artment of F rtificate of i			giene Reg. No O O O	0 20616
134	Dharia	,	1. Decedent's Name (First, Mid	ddle, Last)					2. Date of De Month	ath ZUU Day Ye	3. Time Death
*	Physic /Medi			Ruth Blue	2				June	08 200	08 6:30 рм
	Exami	ner	4a. Facility Name (If not institut	tion, give street and nur	mber)		4b. City, Town, o		ith	4c. County of D	
			5. Social Security Number	re Potomac	7. Age (In yrs. last	hirthday)	If Under 1 Year	Potomac If Under 24 Hr	s. 8. Date of Bir		itgomery Birthplace <i>(State or Foreign</i>
	Funeral Director		579-05-6404	1□M 2 X F	89	Yrs.	Months Days	Hours Mir	ı. (Month, Da	y, Year) r 26,1918	Poland
	land ow rt		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City, T	own or Lo	cation				10d. Inside City Limits
	Mary I-f sh fied a	Į.	Virginia	Loudoun			М	iddleburg			1 ☐ Yes 2 🛣 No
	or 288	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
	23a ust b		56057 Mor	intville Road				20117			5.A.
38	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divorce	Armed Fo arried 1 ☐ Yes If Yes, Giv	2 ⊠ No ⁄e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗷 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No erto Rican, etc.)	. 14. Race - A Black, V Specify:	merican Indian, Vhite, etc. White
21215-0036	be filed within 72 hours tral Hygiene. d other than "natural"; event, the Medical Exa	Completed	15. Deced (Specify only hig Elementary/Secondary (0-12	ent's Education hest grade completed) College (1		(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of w	orking	16b. Kind of Busine	ess/Industry
212	d within giene. er than " the Mec	ĕ	Liententary/occordary (0-12	1 1	1-401 0+)		Yoga In	structor		F	itness
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<u>ya</u>	should be and Mental marked o	은	Abraham '						auline Blau		
Mai	es 1 and 2 should b of Health and Ment f item 27 Is marked r other traumatic e		19a. Informant's Name/Relation							er, City or Town, Stai	te, Zip Code)
	1 and Healt em 2		Jeffrey Blue 20a. Method of Disposition	- 50n	20b. Place	e of Dispo	Box 203, M	1	Date	20c. Location - City	or Town, State
Baltimore,	Pages ment of lant; if its		1 ☐ Burial 2 ☑ Crematio 4 ☐ Donation 5 ☐ Other		State		natory or other place Crematory	1 1	/12/2008	Brentwood,	Maryland
Rail	permit. Page Department (Important; if any injury or		21. Signature of Funeral Servi	te Liopinsee	lan-	H	2. Name and Addre ines-Rinald L800 New Ha	i Funeral			Maryland 20904
	Physician		23. Part1. Enter the disease shock, or eart failure. Limm wate Couse (Final disease or condition resulting in death)	or complications that c ist only one cause on e	raused the death. I each line.		er the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
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	outed Id	Examiner	if any, leading to immediate cause. Enter Underlying	Due to	or as a consequen	ce of):					
68760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to	(or as a consequen	ce of):					
.O. Box 68	The law requires that the death certificate has been signed by the attending place 2 should be detached for use as to	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐ Live b	tcome pf pregnancy birth 2 Fetal de nant at time of deatl own	eath 3[Ectopic pregnancy	/		23d. Date of Month	delivery Day Year
_	w requires that been signed b should be deta	by	Part II. Other significant conc	litions contributing to de	eath but not resultin	ng in the u	nderlying cause giv	en in Part I.		obacco use contribut Yes 2 □ No 3 □	te to the cause of death? Probably 4 DUnknow
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<u> </u>	sician: Th certificate rector, pag	Be	25. Was case referred to med examiner?	1					eath (Check only o	one)	
0	ys dir is	ျ	1 Yes 2 No			/Outpatier		4 LA Nursing		dence 6 Other (Specify)
on C		ion:	27. Manner of Death 1 Natural 5 □ Pen	unig .	th, Day Year)	Bb. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe	how injury occurred	
UNISION	or Atten after deat Director: in by the	Certification:	3 Suicide 6 □ Cou	stigation ld not be ermined 28e. Place buildi	of injury - At home ing, etc. <i>(Specify)</i>	e, farm, str		163 2 10	28f. Location (City or To	Street and Number o wn, State)	r Rural Route Number,
_	Hospital 4 hours Funeral ely filled	edical Co		ying Physician: To the cal Examiner: On the b and man							
	To the I within 2 To the I сотрlet	Mec	29b. Signature and title of cert				29c. Licens	e number		29d. Date signed (N	fonth, Day, Year)
)	٢		•	loo.			D00	54566		6/10/08	
	Q		30. Name and address of pers	on who completed caus	se of death (Item 23	Ba) (Type,				1. 1 - 0	
_			Sunitha BL	·				-1-12	Silvensi	oring o	1020902
	St: Regist	ate rar	31. Date filed (Month, Day, Ye	1 2008 32	Registrar's Signature	60	will.	,),	7020902

			i icase i	State of Man					•		_	
			For State	State of Mary			e of Death	and Me		Reg. No.	008	20611
			Registrer 1. Decedent's Name (First, Middle, Last)				0 0, 000	2.	Date of Dea	ith		3. Time of Death
	Physici		James Francis	Proun				.7	Month une 1	Day	Year 2008	6:00A M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City,	Town, or Location of		une 1	4c.	County of Deat	th
			Fort Washington	Health &	Rehab.	Fo	rt Wash:	ingto	n	Pr	ince (Georges
	Funeral		5. Social Security Number 6. Sex	7. Age (li	n yrs. last birthoay) Yrs.	Months		Min. 8.	Date of Birth (Month, Day	h /, Year)	9. Birt	thplace (State or Foreign buntry)
	Director		215-36-3512 Supplies the State of December 1	·	67				March	22	,1941	Md.
	yland how		10a. State 10b. County	10	Oc. City, Town or Lo	cation					-	10d. Inside City Limits
	Ba-f s	ctor	Md. PG		Fort	Wash	ington					1X Yes 2 No
	ith th	Die	10e. Street and Number			10f. Zip	20744			•	zen of What Co	
	72 hours after death with the Maryland neturel', or Iteme 23a or 28a-f show dical Examinar must be molified at	Funeral Director	12021 Livingst	on Road 12. Was Decedent Eve	arin IIS 13	Was Dece		nin? (Specif			ted St	
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d 2	Hygi Hygi ther int, I	Be Co	17. Father's Name (First, Middle, Last)		11	00u			irst, Middle,			
<u>a</u>	D = D =	To B	James R. Brown				Erna	Bu	tler			
Maryland 21215-0036	2 sh and ie m		19a. Informant's Name/Relationship (Ty)	эө, Print)			(Street and Number		Route Numbe	r, City o	r Town, State, I	Zip Code)
	s 1 and if Health item 27 other tr	į į	Charles Brown/s	on	20b. Place of Dispo cemetery, crei	To We	ndia Pla Irlboro,	Md	2077	2	cation - City or	Town State
Baltimore,	Separa		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R						08			
Ē	permit. Page Department Importent: If any injury or once.	l i	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		Riverdal		rematory nd Address of Facilit					le, Md.
Ba	Depril impo	9 5	Mamma	Hode				ноа			wards tland.	F.H. Md.20746
			23a. Part1 Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the							o z u i u j	Approximate Interval Between
	Physician -	9 9	Immediate Cause (Final disease or condition	1:1		incli						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co								9
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rd	w require been sig should b								1 🗆 Y	/es 2	□No 3□P	robably 4 Onknown
ecc	e law r has be je 2 sh	Completed							24a. Was autop	sy	prior to	utopsy findings available completion of cause of
al B		Cou								rmed? 2 Z No	death?	2 17 No
of Vital Records,	Physicien: this certific	Be c	25. Was case referred to medical examiner?	lospital:	- Ten:		Other		Check only o			
of	ding Phy h. After this funeral di	n: To	1 Yes 2 No	28a. Date of Injury	2 ER/Outpatier 28b. Time o		28c. Injury at		d. Describe h		6 □Other (Spe y occurred	ecify)
ion	Attending r death. ector: After by the fune	atlo	1	(Month, Day Ye	ear) Injury	М	Work? 1 ☐ Yes 2 ☐	No				
Division	r Attender der deathirector:	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, str Specify)	eet, factor	y, office	28	f. Location (S City or Tow			ural Route Number,
	urs af	O		<u> </u>								
	To the Hospitel or Attent within 24 hours after deati To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physical Examination	icien: To the best of marker: On the basis of ex and manner stated	amination and/or in	h occurred vestigation	at the time, date an , in my opinion, dea	id place, and th occurred	d due to the o at the time,	cause(s) date and	and manner a I place, and due	s stated. e to the cause(s)
	ro the vithin ro the comple	Me	29b. Signature and title of certifier			29	c. License number			29d. Dat	e signed (Mon	th, Day, Year)
)			M Sil	m.n		0	45365			06-	18-20	~B
			30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type,	Print)	/	/1.1 /	at 11	Ad.	ton h	11. Day, Year) 28
	-0		Michael Sid	22. Registrar's	Signature	vings	for no 7	10/1	11 00	7	1/	
	Sta Registr		JUN 2 5 2008	2. Hogistial's	I Los	10						

ORIGINAL

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			For State Registrar	State of Marylan		irtment of H <i>tificate of L</i>			giene Reg. No. 🤈 🕦 (2.0	00610
			Hegistrar Decedent's Name (First, Middle, Last)					2. Date of De	eath 201	$38 \pm$	3. Time of Death
-	Physicia		James Warren Brook	K S				Month June	6 2	Year 2008	10:45 A™
4	/Medic	-6	4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Death		4c. County o	of Death	
			Union Hospital			E1kton			Ceci		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday). 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	Country	,
	Director		212-34-0581 Usual Residence of Decedent		71			Sept.	27, 1936	Ma	ryland
	yland now at		10a. State 10b. County	10c. City	, Town or Lo	cation				10d	. Inside City Limits
	e Mar a-f st tified	ctor	Maryland Cecil	F	Rising	Sun					1 □Yes 2/□No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of WI	hat Country	?
	sath w	eral	275 Lombard Rd.	. Was Decedent Ever in U.	5 10 1	21911	anneia Origin? /Co	acify Voc or N	USA 14 Bace	- American	Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1954-	,	Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2[X] No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecily Yes of No Rican, etc.)	Black Specify:	, White, etc	2.
Maryland 21215-0036	n 72 hour "natural edical Ex	Completed b	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a Deced	lent's Usual Occupa kind of work done o OO NOT use retired	ation during most of work	ing	16b. Kind of Bus	siness/Indu	stry
12	within ene. than the M	dшc	Elementary/Secondary (0-12) 5	College (1-4or 5+)		k Driver	,		Transp	ortat	ion
9	e filed val Hygie other i	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Surname		
ılan	uld be Aenta rked tic ev	To B	Joseph Brooks				Helen F	loop			
lary	and hardis ma		19a. Informant's Name/Relationship (Type	. Print)	19b. Mailin	ig Address (Street a	and Number or Rui	al Route Numb	oer, City or Town, S	State, Zip C	ode)
2,	and tealth m 27 her tr		Pamela R. Brooks/Wi			Lombard 1		ng Sun	, MD 219		n State
Jore	ages 1 nt of 1: if ite		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Rer	moval from State	emetery, cren	natory or other plac	e)				
Baltimore,	artmer ortant: Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			Cemetery . Name and Addres		2-2008	Port Dep	osit,	MD
Ba	permit Depar Impor any Ir	l h	Kichard L.	Goodie	•	R.T. Foat	Queen St.	, R1S1	ng Sun, M		911
	Physician	i	23a. Part1 Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	a se on each line.			g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	`					
	200	Jer	Sequentially list conditions, in a sequentially list conditions, in a sequential cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence)		ATION					AYS
	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	CORONANY		MY DISE	ASE			<u> </u>	EARS
50,	oe exe cian a ourial-l		resulting in death) cast	Due to (or as a consequence	,						60.00
68760,	cate b	dical	d.	CHRONIC OF	STRUCT	WE PULL	LOWALY D	ISEASE		- 1	EARS
.O. Box (death certi e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery oth D	ay Year
Δ.	that the de led by the a detached		Part II. Other significant conditions contr	ibuting to death but not resi	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use contri	ibute to the	cause of death?
rds	quires n sign	d by						1 🗷	Yes 2 □ No	3 ☐ Probal	oly 4 Unknown
00E	The law requires that the site has been signed by the bage 2 should be detache	Completed						24a. Wa	s an 24b. V	Vere autops	sy findings available bletion of cause of
E E		mo.	-					perl 1□ Yes	formed? d	leath?	□No
/ita	sician: certifical rector, p	Be (25. Was case referred to medical examiner?	onital:		Out	26. Place of Dea	th (Check only	one)		
or \	si si	မ	1 ☐ Yes 2 ☑ No ☐ 10 27. Manner of Death	spital: 1 Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time of		4 □ Nursing H		how injury occurre		
no	ling After fune	ion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Worl	k?" Yes 2 □ No	200. Describe	now injury cocurr	5u	
Division or Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, str				(Street and Number own, State)	er or Rural	Route Number,
_	Hospital 94 hours 8 Funeral tely filled	alCe	29a. Certifier 1 Certifying Physic	cian: To the best of my knoer: On the basis of examina	wledge, deat	h occurred at the tir	me, date and place	, and due to the	e cause(s) and ma	nner as sta	ted.
	To the Ho within 24 I To the Fu completel	ledical	one)	and manner stated.	aon ang/or in			Too at the time			
	Viith To	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed		
•			J MD		00=\ /T		* - 11		2-446	, , , a	0
5	+ 1 VA		30. Name and address of person who com	l-306 North			ELHTOW	MARYC	MO 219	41	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa		houle				•	

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** 14, 1:30P. M Lillian Conley Baugher June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mount Airy 2481 Mullinix Mill Road Howard If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year, July 15, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign
Country) **Funeral** Year) Days 1 □ M 2 □ X Months 89 West Virginia 216-01-9547 1918 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard Mount Airy 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2481 Mullinix Mill Road 21771 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) 12 Cost Accounting Analyst Western Electric d 2 should be filed with and Mental Hygie. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ev Ronald Burton Conley Virginia Edna Sweitzer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry G. Baugher - Husband 2481 Mullinix Mill Road, Mount Airy, Maryland 21771 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Moles worth Williams P.A., Funeral Home Mout 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Jylau /Medical Due to (or as a c mequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 X No certificate 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2[**X**No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending Injury 1 XNatural death. within 24 hours after death To the Funeral Director: filled in by the

Records, P.O. Box 68760 Division or Vital

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D44793

29b. Signature and title of certi

29c. License number 29d. Date signed (Month, Day, Year)

June 16, 2008

30. Name and address of person who, ompleted cause of death (Item 23a) (Type, Print)

6730 Holabird Avenue, Dundalk, Maryland Ali Sanai M.W.

State Registrar

Medical

31. Date filed (Mooth, Day, Year) UN 2 5 2008



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			For	State	of Marylar					and M	lental Hy	giene				
_			1 - State Registrar			Cei	rtifica	te of L	Death			Reg. No.	201	18	206	115
	Physici	an	1. Decedent's Name (First, Middle, L Wanda Maxin		rv						2. Date of De Month	Day		ear (3HIME ON	Death M
	/Medic		4a. Facility Name (If not institution, ga				4h City	Town, or	Location o	of Death	06	20	County of)8 Death	0740	141
ž.	Examin	er	WMHS-Braddock Car		umbor)			ber1a		, Dodan			llega			
	Funeral		Social Security Number 6.	Sex	7. Age (In yrs.	last birthday)	If Unde Months	r 1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da	rth			lace (State or	r Foreign
	Director		216-30-1647	1 □ M 2 X □ F	75	Yrs.	WOITUIS	Days	Hours		July 1		32		land	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	0d. Inside Cit	y Limits
	Maryl f sho ied a	tor	MD Alleg	any	1	LaVale									1 ☐Yes	¾ □ No
	r 28a r notif	irec	10e. Street and Number				10f. Zi	p Code				10g. Citi.	zen of Wh	at Coun	try?	
	th with 23a oust be	al D	726 Valley Vie	w Dr.				2150	2			U.S	.A.			
	er dea tems ter mi	Funeral Director	11. Marital Status	Armed F	cedent Ever in U orces?	.S. 13. \	Was Dece If Yes, spe	edent of Hi ecify Cuba	ispanic Orig an, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	D-	 Race - Black, 	America White,		
0000	rs afte r', or i	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, G Year or	2 X No Sive Dates:		1 □ Yes	2 No	Specify:				Specify:	Wh	ite	
3	2 hou atura cal Es		15. Decedent's l	Education		16a. Deced	dent's Usu	ual Occupa	ation			16b. Ki	nd of Busi	ness/inc	lustry	
2	thin 7. e. an "n Medi	Completed	(Specify only highest g Elementary/Secondary (0-12)		(1-4or 5+)	(Give life, L	DO NOT L	ork done d use retired	during most ()	t of worki	ng					
V	ed wit ygien ier tha	Con	12			Rece	ptio	nist					duca		l	
alla	be file	Be	17. Father's Name (First, Middle, Las	,							(First, Middle				-	
7	hould d Mer narke natic	To	Emil Peter Kam 19a. Informant's Name/Relationship			10h Mailin	a Addron	n (Stroot :			t E. ((
2	id 2 si Ith an 27 Is r traur		Curtis Durell				_				LaVale				Code)	
บ์	s 1 ar f Hea item item		20a. Method of Disposition	<u> </u>	20b. I	Place of Dispo					ate	-	cation - C		wn, State	
2	Page Tent o		1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		notate	est Law				une :	22 08	LaV	ale,	MD		
Dalifillio	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	ensee	$\overline{\alpha}$	- 1			ss of Facility	110	afer Fu	ınera	l Se	rvic	e, P.A	١.
0	e a m re		John	taker	6, 4					Hwy.	, LaVal	Le, M	ID 2	1502		
			23a. Part1 Enter the disease, or conshook, or heart failure. List on	mplications that y one cause on	caused the deat each line.	th. Do not ent	er the mo	de of dyin	g, such as	cardiac o	or respiratory a	arrest,			Approximate Interval Betwoonset and D	veen
) V	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a	ENAL	7-19	126	IRE	;					<u> </u>	DAY-	
	Examiner			Due to	o (or as a consec	uence of):	M	11/	OM	1				>	Yea	-
O, .		er	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a consec	uence of):	/ /	10	0//	/ /					1 - 6	
4	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c												
5	e exe lan ar urial-t	EX	resulting in death) Last	Due to	o (or as a consec	quence of):										
0,00,	icate be executed physician and s the burial-transit	dical	•	d												
0 K	ding p	/Me	IF FEMALE:	23c If yes o	utcome pf pregn	ancy							20-1 D-1-	-6 (-1)		
2 2	atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Feta	al death 3□	Ectopic p	oregnancy	,			4	23d. Date Mont		-	'ear
;	the d	nysi	1 Yes 2 No 9 Unknown	9□Unk				, , , , _								
Ľ	The law requires that the death certifing the has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions	contributing to	death but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did	tobacco u	ise contrib	ute to th	ne cause of d	eath?
COIOS,	equire en siç ould b	Completed by	- MYHERIE	- / \ 25/				_			1 🗆	Yes 2	⊴ No 3	□ Prob	ably 4 □U	Inknown
נ	law r las be	ple									24a. Was		24b. W	ere auto	psy findings a	available ause of
ב =	The cate h	Con									perf 1□ Yes	ormed?	de	ath?	2 No	
<u> </u>	ician Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Oth		of Death	(Check only	one)				
5	Phys this ral dir	- To	1 ☐ Yes 2 ☐ No 27. Manner of Death	16	Inpatient 2 ☐ e of Injury	ER/Outpatien			4 LI Nu		me 5 Res 28d. Describe				y)	
200	ding h. After funer	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Mo	onth, Day Year)	Injury	' _м]	28c. Injun Work 1 □	k? Yes 2∐t		zod. Describe	now injur	y occurre	1		
2	Atten r deat ector by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	be 28e. Plac	ce of injury - At h	ome, farm, str	eet, facto	ry, office		:	28f. Location			or Rura	l Route Num	ber,
5	s afte	Sert	4 Homicide	Duli	ding, etc. (Speci	197					City or To	wn, State	")			
	tospit thour uner:				he best of my kno basis of examina)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s.	Medical	one)		inner stated.			c. License							Day, Year)	
	Nii G	_	29b. Signature and title of certifier	7 1	7		٠,	_		1		Zau. Dal	o signed	ovioriui,	Day, rear)	
			30 Nama and disaster in the	o completed an	use of death (Iter	n 230) (Time			004				12	4	8.	
	9		Shiv Khanna	m N /	221 Enc-	+ NAto	nall	419h	way	, ko	Vale	mn	21	50	3	
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature	9	1.5			V	,	1 12	J U (<u> </u>	
	Registr	ar	4444 2000	100	18	CHORAGE Z	-									

	ter death with the Maryland There must be notified at There must be notified at	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.	To Be Completed by Finarel Director

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	for State Registrar	State of iv	Cei	rtificate of L		ivientai myt F	Reg. No. 2008	3 20616
	1. Decedent's Name (First, Midd	le, Last)				2. Date of Dea Month	ath Day Year	3. Time of Death
ian ical	CHARLE	S RAN	IDALL	CRAWFOR	RD	June	16, 2008	
ner	4a. Facility Name (If not institution			4b. City, Town, or			4c. County of De	ath
	4031 Feder				ettsvil		Har	
	5. Social Security Number 571–58–3377	6. Sex 7. A	ge (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	1940 9. Bi	irthplace (State or Foreign Country) Ohio
	Usual Residence of Decedent 10a. State 10b. Count	/	10c. City, Town or Lo	ocation				10d. Inside City Limits
ō		arford	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					1 ☐ Yes 2 No
Funeral Director	10e. Street and Number	arrord		10f. Zip Code	rettsv		10g. Citizen of What C	Country?
0	4031 Fed	eral Hill	Road		21084	_	United	States
era	11. Marital Status	12. Was Decedent		Was Decedent of Hi If Yes, specify Cuba				
표	1 ☐ Never Married 2 ☐ Ma	Armed Forces rried 1 M Yes 2 If Yes, Give	? No			to Rican, etc.)	Black, Wh	iite, etc.
þ	3 Widowed 4 □ Divorce	If Yes, Give Year or Dates:	Vietnam	1 ☐ Yes 2 🗓 No	Specify:		Specify:	White
ted	15. Decede	nt's Education est grade completed)	16a. Dece	dent's Usual Occupa	ation	rkina	16b. Kind of Busines	s/Industry
lg d	Elementary/Secondary (0-12)	College (1-4or	5+)	kind of work done of DO NOT use retired		,,,,,,,,		ed States
Completed by	12	7	I I	<u>lathemat</u>		(5)		ernment
Be	17. Father's Name (First, Middle		a				Maiden Surname)	
은	William	Howard	Crawfor		Eunic			
1 1	19a. Informant's Name/Relation	4					er, City or Town, State,	
9	James B. Smi 20a. Method of Disposition	th (POA)		W. Bel		Date A	20c. Location - City of	MD. 21001
	1 ☐ Burial 2 ☐ Cremation		20b. Place of Dispo cemetery, crea			0./0000	•	
	4 Donation 5 Other (Carroll	Cremati 2. Name and Addres	on $0/1$	8/2008	Hampste	ad, Marylan
	21. Signature of Funeral Service	Claraco	1		A T	.G. Kui	tz & Sor	r Funeral
1	23a Part 1 Enter the disease of	or complications that cause		Iome, P.			sville, N	Approximate
l s	23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final	t only one cause on each	ine.	ior the mode or dyin	g, odon do odiqid	o or respiratory at	1031,	Interval Between Onset and Death
	disease or condition resulting in death)	_a	umenia	/				
		Due to (or as	s a consequence of):					
<u>-</u>	Sequentially list conditions,	b. Due to (or a	consequence of):	~				
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter of John 19 Cause (Disease or injury that initiated events	<	,					
Ixa	resulting in death) Last	C. Due to (or a	s a consequence of):					-
<u>a</u>								
edical		u.						
M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		7=			23d. Date of d	lelivery
icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant :		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>			Month	Day Year
hys	9 ☐ Unknown	9□Unknown						
Completed by Physician/M	Part II. Other significant condit	ions contributing to death		nderlying cause give	en in Part I.	23e. Did to		to the cause of death? Probably 4 Unknown
lete	D. O.t.	Kelletin				24a, Was	an 24b. Were	autopsy findings available
Ę	- year-our	10 10 47 9				autop perfo	rmed? death'	autopsy findings available o completion of cause of ?
	25. Was case referred to medic	al l			26 Place of De	1 Yes ath (Check only o	2 No 1 □ Ye	es 2 No
o Be	examiner? 1 ☐ Yes 2 No	Hospital:	ient 2 ☐ ER/Outpatier	nt 3 DOA Othe			ience 6 □Other (Sp	ancify)
n: To	27. Manner of Death	28a. Date of In	ury 28b. Time o				now injury occurred	
tiol	1 Natural 5 Pendi 2 Accident invest	ng (<i>Month, D</i> igation	ay Year) Injury		<br Yes 2 □ No			
dical Certification:	3 Suicide 6 Could 4 Homicide determ	Zoe. Flace of it	ijury - At home, farm, str rtc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
S S	29a. Certifier 12 Certify	ing Physician: To the bes	t of my knowledge, deat	h occurred at the tir	me, date and plac	e, and due to the	cause(s) and manner	as stated.
dici	(Check only 2 Medica one)	Examiner: On the basis and manner s	of examination and/or in tated.	vestigation, in my o	pinion, death occ	curred at the time,	date and place, and d	ue to the cause(s)

d

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 25

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLAUDIA KNOKEN, 1308 BUSINESS CENTERWAY 32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of ertificate of	Health and M Death	fental Hyg	liene 20	08 2061
	Physic /Medi		1. Decedent's Name (First, Midd Kenneth De					2. Date of Dea Month June	Day	3. in corpeath 008 8:39 A
	Exami		4a. Facility Name (If not institution Baltimore Wash	-		4b. City, Town, Glen I	or Location of Death Burnie		4c. County Anne	
	Funeral Director		5. Social Security Number 294–18–0174	6. Sex 1 M 2 □ F	ge (In yrs. last birthday 84 Yrs.) If Under 1 Year Months Days		8. Date of Birth (Month, Day Feb. 21	Year)	Birthplace (State or Foreign Country) Ohio
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne	Arundel	10c. City, Town or L	ocation na Park				10d. Inside City Limits 1 □ Yes 2 \overline{\
	th with the 23a or 28a	al Direc	10e. Street and Number 46 Lockleven	Drive		10f. Zip Code 21 1	46	1	0g. Citizen of W	•
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'v. Medical Examinar must be retified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma. 3 ▼ Widowed 4 □ Divorce	If Voc Civo	?]No <i>WWTT</i>	. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Spo oan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. : White
21215-0036	thin 72 hc re. an "natur Medical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or	(Giv	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of working ed)	ng	16b. Kind of Bu	siness/Industry
	be filed wirtal Hygien dother the event, the	Be	17. Father's Name (First, Middle	, Last)	E	ngineer	18. Mother's Name		Maiden Surnam	nghouse ®)
Maryland	d 2 should Ith and Men 7 is marke traumatic	은	Tom F. Cowan 19a. Informant's Name/Relation: Michael Cowan	ship (Type. Print)	l l		t and Number or Rura		; City or Town,	
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra once.		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other (5	3 ☐ Remeyal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place ans Cemet	June)ate 11,	20c. Location -	City or Town, State
Balti	permit. Pages 1 Department of P Important: If ite any injury or ot once.		2) Signatur Funeral Service		-00	Name and Addr	Sons, P.	.A. Seve	erna Par erna Par	k Funeral Home k, MD 21146
	Physician /Medical	(23 . Part1. Enter the disease, o shoc or heart failure. List Immediate Cause (Final disease r condition resulting in death)	-a. my	d the death. Do not er line.	ter the mode of dy	ing, such as cardiac c	or respiratory arr		Approximate Interval Between Onset and Death
	Examiner	Jer		b	s a consequence of):					
,00	ficate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cales Ent III minimized Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	s a consequence of):	-				
O. Box 6	death certi e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□ Ectopic pregnan □ Other <i>(specify)</i> _	cy		23d. Date Mor	e of delivery hth Day Year
rds, P.	ires tha signed	þ	Part II. Other significant conditi	ons contributing to death I	ven in Part I.	23e. Did tob	A	ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown		
<u> </u>	The law ate has b page 2 sl	Completed	HYPERT	TOUSION				24a. Was ar autops perforn 1 □ Yes 3	y p	Vere autopsy findings available rior to completion of cause of eath? □Yes 2□No
f Vita	ysician s certifi director	To Be (25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	l Hospital: 1 ☐ Inpati	ient 2 ER/Outpatie	nt 3 DOA Oth	26. Place of Death	(Check only on	9)	
Ë	ling After Tune	ertification: T	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	gation	ury 28b. Time o lnjury	Wor		28d. Describe ho		
Division	al or Attency after death Director: d in by the I	ertific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Place of In building, el	jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office	2	8f. Location (St. City or Town	reet and Number, State)	er or Rural Route Number,

Jenneth Cowar

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of dertifier

0040012

29c. License number

29d. Date signed (Month, Day, Year) 3006 UNE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POULTON 31. Date filed (Month, Day, Year) 1 0 2008

State Registrar

Medical

To the Hospital or Attending Physician: The law requir

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 20518 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:45P. [™] JUNE 2008 RUPERT 14, NMN CUNEEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REEDERS MEMORIAL HOME BOONSBORO WASHINGTON If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
JULY 22, 19 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months 1XM 2□F Yrs Director 394-18-4874 1923 WISCÓNSIN Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location show 10d. Inside City Limits notified at 1 ☐ Yes 2 No Director MARYLAND 28a-f WASHINGTON SHARPSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be items 23a Funeral 5434 SHARPSBURG PIKE 21782 death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ttem 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner filed within 72 hours after 1 Ness 2 No 1942— If Yes, Give Year or Dates: 1948 1 Never Married 2 Married or 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 Widowed 4 Divorced 1948 WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 4 REAL ESTATE AGENT REAL ESTATE AGENCY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fill lealth and Mental H Be h and Mental RAYMOND CUNEEN 2 MARY RUBBERT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2. south earth of Health a contant: If Item 27 is 5434 SHARPSBURG PIKE, SHARPSBURG, MARYLAND BARBARA PRYOR/LEGAL GUARDIAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donat 5 ☐ Other (Specify) STAUFFER CREMATORY 6/16/2008 FREDERICK, MARYLAND 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME, PA 21. Signa Paul M.Dean 7606 Old National Pike, Boonsboro, MD 21713 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final Physician Ten; Salentiz Condis varado disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaining Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chana otherwater 1 | Yes 2 | No 3 | Probably 4 | Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy 2 Z NO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4 No ို After thi funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 ANatural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Accompletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) -DE MO P108) a BORE 16 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. VASANT DATTA, 340 MILL STREET, HAGERSTOWN, MARYLAND 21740 5H-6+1 301-739-7100 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 1 6 2008

8-04366		Please Type or Print in Blac					ble.	
Villiam R. Croc	kett,	Jr. State of Maryland / D			nd Mental Hy	giene	200	0000
		Registrar	Certificate	of Death		Reg.	No. 200	
Physici Medical Exam		Decedent's Name (First, Middle,Last)			2	. Date of Death Month E	Day Year	3. Time of Death
viedicai Exam	ner	WILLIAM R. CROCK	ETT, JR			June 7, 200		0515 hrs
		4a. Facility Name (if not institution, give street and number) McCready Hospital		4b. City, Town, o	r Location of Death		4c. County of Death Somerset	
- Francisco			n yrs. last birthday)		ar If Under 24Hrs.	0. Date of Birth		theless (State
Funeral Director			•	Months Day			(MM/DD/YYYY) 9. Bir Foreig	n
Directo.		220-66-4679 1XM 2 F 5	2	Yrs.		07/09/1	.955 co	untry)Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Loc	cation				10d. Inside City Limits
*			,		6: -12			1 Yes 2 X No
Maryland 28a-f show d at once.	to	Maryland Somerset 10e. Street and Number		10f. Zip Code	field	100	. Citizen of What Cour	
72 hours after death with the Maryland "antural", or items 23a or 28a-f sho al Examiner must be notified at once.	Director					log		my:
ith th 23a notif		26974 Plantation Road 11. Marital Status 12. Was Decedent Eve	II.O. T40.1		1817	-15 - M N -	USA	
eath w	Funeral	1 Never Married 2 X Married Armed Forces?	1		ispanic Origin? (Spe an, Mexican, Puerto R		White, etc.	can Indian, Black,
er de		1 Yes 2 X	No 1	Yes 2 X No	a anosifu		Specify: Whi	10
hours afte "natural", Examiner	l by	or Dates: 15. Decedent's Education (Specify only highest grade completed to the complete specific or Dates:	ted) 16a Decer		ation (Give kind of wo	rk done 11	6b. Kind of Business/I	
2 hou "nat	ec	Elementary/Secondary (0-12) College (1-4 or 5+)	during		e. DO NOT use retire		ob. Faile of Dabilloon	ridustry
336 thin 7 than than)du	12		Vend	or		Magazir	nes
5-0(iled wi Hygier I other	Completed	17. Father's Name (First, Middle, Last)			18.Mother's Name (First, Middle, Ma		*
	Be	William R Crockett Sr			Gayle Lo	roman		
	မ	William R. Crockett, Sr. 19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Stre	et and Number or Ru	ral Route Number	er, City or Town, State	, Zip Code)
		Bonnie Crockett (Wife)	2697	74 Planta	tion Road	- Crisf	ield, MD 2	21817
re, ME s I and 2 s of Health a If item 27		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	20b. Place of Disp crematory or	osition (Name of ce	emetery,	Date 2	20c. Location - City or	Town, State
MO Pages ent of mit: 1		4 Donation 5 Other Specify:	_	e Memorial	Park 06/1	1/2008	Crisfield,	Maryland
Baltimore, permit. Pages I a Department of He Important: If ite		21. Abyature of Fune al Service Licencee		2. Name and Addres			SONS FUNER	
E E E		Mary Beth Bradshaw-Pruitt	ant !	806 W. Ma			d, MD 2181	
Physician		23a. Part l. Enter the disease, or complications that caused the failure. List only one cause on each line.	death. Do not ente	er the mode of dying	, such as cardiac or r	espiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a. Pulmonary Thromb	ooembolism					Death
Adminier		or condition resulting in death) Due to (or as a consequence)	ence of):					
	_	Sequentially list conditions, b.						
	ine	if any, leading to immediate Due to (or as a consequence of the property of the consequence) Due to (or as a consequence) C. C.	ance or):					1
=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequ	ence of):					
executed an and al - transi	ical E	d						
be exician		UNPENDED AMENDED						
760 icate	Physician/Med	IF FEMALE: 23c. If yes, outcome of the line birth	of pregnancy				23d. Date of delivery	
68 certif nding ise as	jan	past 12 months?	o of death	Fetal death 3	Ectopic pregnan	СУ	Month [Day Year
30X death	ysic	1 Yes 2 No 9 Unknown 9 Unknown	e or death 5	Other (Specify)	-			
D. E		Part II. Other significant conditions contributing to death bu	t not resulting in th	e underlying cause	given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
cords, P.O. Box 68760, aw requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit	Completed by					1 Yes	2 V No 3 Prob	ably 4 Unknown
ds requir	ete					24a. Was an		topsy findings available
COI e law e has l	ם					autopsy perform	ed? death?	completion of cause of
Re ificate		25 Was sace referred to medical		00 Di	- (Death (Obs.)	1 Yes 2	No 1 Y	es 2 No
Division of Vital Records, tal or Attending Physician: The law requints after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the	å	25. Was case referred to medical examiner? Hospital:	2 V ER/Outpatie		e of Death (Check or Other)		esidence 6 Other	
Pluys Pluys eral d	유	1 V Yes 2 No Impatient 27. Manner of Death 28a. Date of Injury	28b. Time of				esidence 6 Other	:
on of Nading Ph.	ertification:	1 V Natural 5 Pending (Month, Day,Year)		· · · I - ·	Yes 2 No		yary oodan oo	
Sior Attend r death ector: by the	g	2 Accident Investigation 28e Place of Injury	- At home farm st			8f Location (Str	eet and Number or Ru	ral Route Number, City
Divi spital or , tours after	튑	Suicide 6 Could not be determined (Specify)	- At Home, Idini, 3t	reet, factory, office	building, etc.	or Town, Stat		rai Noble Number, City
lospid 4 hour uner:	0	4 Homicide 29a. Certifier 1 Continue Physician: To the best of my ke	owledge death as	rurred at the time	tate and place and d	ie to the course's	e) and manner as at-1	ad .
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner: On the basis of examina						
To with Com	Mec	and manner stated. 29b. Signature and title of certifier		29c. Licen:	se number	12	29d. Date signed (Mo	nth, Day, Year)
		Marie A Mr.		O.C.	.M.E.	1	June 8, 2008	,
		30. Name and address of person who completed cause of death	n (Item 23a)				,	
5		Margarita Korell MD. Assistant Medical Ex	, ,	Penn Street. E	Baltimore, MD 2	1201		
5 EB	ate			/	-,	_		
Regis	rar	31. Date filed (Month Day, Year) 1 2003 32. Restrar's S	Signature	DENELL				

Registrar

Division or Vital Records, P.O. Box 68760,

Funeral Director death with the Maryland 28a-f show Examiner must be notified at Director 23a or Funeral Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. or i Baltimore, Maryland 21215-0036 ģ "natural"; Completed permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any Injury or other traumatic event, the Meonce. Be **Physician** /Medical Examiner Examir The law requires that the death certificate be executed attending physician for use as the buria by Physician/Medical Completed To the Hospital or Attending Physician: Be ٥ Certification: after death | Director: / e Funeral completely filled 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) leted cause of death (Item 23a) (Type, Print) BANS HIGHWAYNILL 31. Date filed (Month, Day, Year) State JUN 1 0 2008

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 8 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** June 10, 6:48 a M 2008 DeLauney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dove House-Carroll Hospice Westminster Carroll County If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1**X** M 2 □ F 234-38-9431 79 Director 23, 1928 West Virginia Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 9818 Braddock Road 20903 USA 12. Was Decedent Ever in U.S. Armed Forces? 1★ Yes 2 No If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify. Specify: White Be Completed by 3 Widowed 4 □ Divorced Confiles. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Procurement Department of Justice : If item 27 is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental Pages 1 and 2 should be is marked of Robert Henry DeLauney Virginia Ann Reardon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health Robert M. DeLauney, Jr./Son 5425 Broadwater Lane, Clarksville, MD 21029 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State June 13 Department of Important: If any injury or Gate of Heaven Cemetery 2008 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Coll 21. Signature of Funeral Service Licens Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only or EDGE PHA LOPATHY Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): 68760. by Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 TYPS 2 No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 (1No 2 No 1 🗆 Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 6 Other (Specify) OVE HOUS Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To HOSPICE Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 Natural 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation ours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and titl of certifier D35378 10+1 23a) (Type, Print) TER ST WEATHJUSTER MD 21157 30. Name and addre +CAVID 555 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 11 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Car1 Edward DEEDS 48 A M linne 2008 4c. County of Death Washington 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hagerstown Washington County Hospital 8. Date of Birth (Month, Day, July 30, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Year) 1919 Hours Days Months Min. Maryland 88 212-14-6549 July Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington Hagerstown Maryland 12 Yes 2 □ No 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 21742 U.S.A. 1321 Outer Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian lt ⊠Yes 2 □ No W.W.II It Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 🔯 No Specify Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) janitorial service owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lula Gruber Deeds Harry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby F. Deeds - wife 1321 Outer Drive, Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ¹⁹2008 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State June 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Hagerstown, Maryland 21. Signature of Funeral Service L 22. Name and Address of Facility Minnich Funeral Home Talend 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) scheme Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

Director

Funeral

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Completed

Be

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Funeral

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "hectical Experiment must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ita Mar

within 72 hours after death with the Marylanc

Baltimore, Maryland 21215-0036

and burial-trar attending physician for use as the buria signed by the a has page 2 s

Examine Physician/Medical þ Completed

Medical

certificate Be မှ Certification: After thin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

death.

within 2 To the I

WH-3H

Division of Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

29a. Certifier (Check only one)

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 120063233 29d. Date signed (Month, Day, Year)

2 🗆 No

1 □ Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 580 Northern Ave ahmod

2008

shahid 31. Date filed (Month, Day, Year)

JUN 1 6

29b. Signature and title of certifier

trar's Signature

Registrar

		-	State of Maryland / De State of Maryland / De Registrar	ertificate of De		Reg.	2008	20623
-	Physicia		1. Decedent's Name (First, Middle, Last) Paul B. Ferrell		2	Date of Death Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death	June 8, 2	4c. County of Death	3.43 p
	Examin	er	4820 Ayondale Road	Hyattsv	ille		Prince Geor	rge's
-1 -2	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days	Hours Min.	Date of Birth (Month, Day, You Sept. 23.	ear) Coui	place (State or Foreign http://
	land t t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	r Location			1	0d. Inside City Limits
	Mary -f sho fied a	tor	Maryland Prince George's Hya	ttsville				1 X Yes 2 ☐ No
	r 28a notif	Director	10e. Street and Number	10f. Zip Code		10g	. Citizen of What Cour	ntry?
	th witl 23a o ist be	ョ	4820 Avandale Road	20782			USA	
	ems er mu	Funeral		 Was Decedent of Hisp If Yes, specify Cuban, 	anic Origin? (Spec Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentel Hygiene. Health and Mentel Hygiene. To 1s marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	δ	1 □ Never Married 21X Married 1 □ Yes 21X No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕱 No	Specify:		Specify: Whi	te
ה ה	72 hc	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed)	ecedent's Usual Occupation Silve kind of work done dur fe. DO NOT use retired)	on ring most of working	7	6b. Kind of Business/In	dustry
7	within ane. than '	dm	Elementary/Secondary (0-12) College (1-4or 5+)	Hair Stylist			Beauty	
2	should be filed with and Mental Hygiene marked other that umatic event, the h		17. Father's Name (First, Middle, Last)		8. Mother's Name (First, Middle, Ma		
U	ld be ental ked o	To Be	Oscar B. Ferrell	c	lema M. Pad	lgett		
2	2 should be filed wo and Mental Hygie Is marked other traumatic event, th	-	19a. Informant's Name/Relationship (Type. Print) 19b. N	lailing Address (Street and	d Number or Rural	Route Number, C	City or Town, State, Zip	o Code)
Ě	and 2 lealth a m 27 ls		Florence E. Ferrell/Wife 48	20 Avondale Ro	ad, Hyattsv			
5	of He of He fitem		20a. Method of Disposition 1558urial 2 □ Cremation 3 156Removal from State 20b. Place of D cemetery,	isposition (Name of crematory or other place)	June	ite 20	c. Location - City or T	
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Specify) Blair	Memorial Park	200)8	Bellwood, Pe	ennsylvania
Baltimor	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee Kyle Collins M9444	22. Name and Address Francis J. Co 500 Universit	llins Funer	ral Home In Silver Spr	nc. ring, MD 2090	01
	100		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying,	such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition Renal Failure					Criset and Death
	/Medical		resulting in death) Due to (or as a consequence of)	:				
	Examiner		Sequentially list conditions, if any leading to immediate b. Diabetes b. Due to (or as a consequence of)					
7	bet Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underh in Cause (Disease or injury that initiated events b. Due to (or as a consequence of) cause (Disease or injury that initiated events c.	•				
Ž	al-trar	xan	that initiated events resulting in death) Last c	:				
58/PU,	ficate be executed graphsician and is the burial-transit	cal	d					
Q	= D 6	ledical			_			-
X Q Q	death certifi e attending d for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 4□ Pregnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deli- Month	very Day Year
j.	the d y the	ıysi	1 Yes 2 No 9 Unknown			7		
7	requires that een signed b nould be deta		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given	in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ğ	quires n sig uld be	ed by				1 Tes	s 2 No 3 Pro	bably 4 Munknown
Hecords,	aw re is kee 2 sho	Completed				24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
	he law ate has k page 2 st	mo;				perform	ed? death?	2 🗆 No
VITAI	sician: The law s certificate has b lirector, page 2 s	Be (25. Was case referred to medical examiner?		26. Place of Death	(Check only one))	
0	Physician: r this certific ral director,	P	1		4 LI Nursing Hon	ne 5 🔀 Residen 8d. Describe how	nce 6 Other (Spec	sify)
	ing Afte une	iio	xxx Natural 5 □ Pending (Month, Day Year) Inju	ury Work?	es 2 No	ou. Describe nov	wingary occurred	
<u>S</u>	he cat	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)			8f. Location (Stre	eet and Number or Ru	ral Route Number,
DIVISION	after Direction by	Certification:	4 Homicide determined building, etc. (Specify)			City or Town,	State)	
	Hospita 4 hours Funeral tely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and manner stated.	death occurred at the time for investigation, in my op	e, date and place, a inion, death occurre	and due to the car ed at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of gertifier	29c. License	number	29	d. Date signed (Monti	n, Day, Year)
	F ≯ F ŏ		MK, tree	D231	.25		June 9, 20	08
7	Ve .		30. Name and address of person who completed cause of douth (Item 23a) (T. M. K. Mohan, MD 6502 Kenilworth Avenue,	ype, Print) Riverdale, MD	20737	7		
	Sta	ate						
	Regist		JUN 10 2008	GOBALL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 19 2008 0855 FLETCHER 06 FRANCES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Year) WMHS MEMORIAL CAMPUS If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Country) Maryland Hours 1 □ M 196-50-7795 82 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County show 1 ☐ Yes 2 No 28a-f sh notified Director Allegany Cumberland MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i 21502 10301 Christie Rd NE U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill h and Mental H is marked oth Be Roy Fletcher Mattie (Whorton) Fletcher ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important; if Item 27 is n any Injury or other traun once. Rt. 6, Box 6432, Keyser, WV Jackie Mayle Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Buria! 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Glendale Brethren Cem Jun 21 08 Flintstone, MD 22. Name and Address of Facility Hafer Funeral Service, P.A. 21. Signature of Funeral Service Licenses 1302 National Hwy., LaVale, MD 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Vist only one cause on each line. Approximate Interval Between Onset immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any local sequence is cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-trai Due to (or as a consequence of) P.O. Box 68760. physician the 1 as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown pate has been signed lead Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 217No 3 Probably 4 □Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a, Was an autopsy performed certificate 2 1No 25. Was case referred to medical examiner? funeral director. 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **∠** No 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death Funeral Director: filled in by within 24 hor To the Fune completely fi To the I

6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

dighway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

29a. Certifier

(Check only

31. Date filed (Month, Day, 5 2008 JUN 2

			For State	State of Ma	arylan		artmer <i>rtifica</i> i			and M			200	0.0	
١.		9	Registrar 1. Decedent's Name (First, Middle, La	st)			Imour	0. 5	Journ		2. Date of Dea		JUB	3. Time (of Death
	Physicia /Medic		ROBERT	LOWELL	F	IROR					June	14,	2008	3:30	AM
	Examin		4a. Facility Name (If not institution, giv						Location o	of Death			y of Death	1	
			Frederick Memor 5. Social Security Number 6. S			last birthday)		ederi	.CK If Under:	24 Hrs.	8. Date of Birth		deric	K place (State	or Foreign
	Funeral Director			15x M 2 □ F		70 Yrs.	Months		Hours	Min.	(Month, Day April 1	8,1938	Mary	yland	or Foreign
			Usual Residence of Decedent		1.0.00										
	arylar show	7	10a. State 10b. County Maryland Washingt	- on		y, Town or Lo							1	10d. Inside 0 1 □Yes	City Limits s 21∑XNo
	the M 28a-f ootifle	recto	10e, Street and Number		na	agerst	10f. Zij	n Code	<u> </u>			10g. Citizen of	What Cour		
	3a or	i D	20003 Boxwood Ci	rcle					21742	2		U.S.			
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Give Year or Dates:			Was Dece If Yes, spe		spanic Ori n, Mexicar Specify:	gin? (Spe	ecify Yes or No- Rican, etc.)		ce - Americ ack, White, fy: whit	etc.	
5	72 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Usu	al Occupa	ation	t of worki	ina l	16b. Kind of E	Business/In	dustry	
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≥ 1)	l and lealth im 27 ther tr		Victoria B. Firor		20h B	20003			Circ.		Hagersto	20c. Location			742
2	ages nt of H		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐		C	emetery, crei	matory or	other plac	e)	June			•		.11
Dallillo	artme ortani Injun		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lices		па	gersto			s of Facilit		2008 Minnich	Hagers			Tand
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•	/Medical Examiner	5.	resulting in death)	Due to (or as	a consequ	uence of):									
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	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	delice di									
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Ų.	ss that gned b	by Pi	Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco use cor	ntribute to t	he cause of	death?
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222	tal or Atte s after dea al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ury - At ho c. (Specify	ome, farm, sti	eet, factor	y, office			28f. Location (S City or Tow		ber or Run	al Route Nu	mber,
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exam	nysician: To the best miner: On the basis o and manner sta	f examina	wledge, deat tion and/or in	vestigatio	n, in my o	pinion, dea	nd place, ath occur	and due to the ored at the time,	cause(s) and n date and place	nanner as s e, and due t	tated. o the cause	ı(s)
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			1 /yy	(Lue 1	100			MDD35	100		(2/17	-/2	000	5
	5H-10		30. Name and Address of person who Dr. Myung Hee Nam					reder	ick.	Mars	vland				
	Sta	te	31. Date filed (Month, Pay, Year)	32. Registra					,		,				
	Daniel Land		TUNE OF	11117 I Nº 0.		A. all	AT A	0							

Patricia Lee Gilch		- For State	ate of I	Marylan				Health Death	and	Menta	al Hyg	giene			
	F	Registrar 1. Decedent's Name (First, Midd	- (4)			erunc	ale of	Death			Ιż	. Date of Dea	eg. No	-200	3 ime of 2
Physiciar Medical Examin	-			0.							1	Month June 17, 2	Day	Year	1015 hrs
✓ \		Patricia 4a. Facility Name (if not institution	Lee		lchr	1st	14	b. City, To	wn, or Lo	ocation of	Death	Julie 17, 2		c. County of Deat	h
		19927 Sweet Gum Ci	-		,01,			Germa						Montgomery	
Funeral	٩	5. Social Security Number	6. Sex		Age (In y	rs. last bir	thday)	If Under	1 Year	If Under	24Hrs.	8. Date of Bi	rth(MN	VDD/YYYY) 9. Bir	rthplace (State or
Director		577-62-1054	1 M		63		Yrs.	Months	Days	Hours	Min.	Nov. 8		Forei	Washington,
	-	Usual Residence of Decedent	I M	2 AF	- 05		115.	1				NOV.	٠, و ١	1 744	DC DC
any	ŀ	10a. State 10b. County	-		10c. (City, Town	or Locati	on							10d. Inside City Limits
p wo si	_ [Maryland Mont	omery	7		Germa	ntow	n							1 X Yes 2 No
urylan Ia-fsi	ま	10e. Street and Number	, ,					10f. Zip C	ode			1	10g. Ci	tizen of What Cou	intry?
S6 the Market or 28 stiffed a	Director	10027 C C-	C	1 . A	_4	1 2		20	874				Und	ited Stat	t o c
with t		19927 Sweet Gu		Was Deced				s Decedent	of Hisp			cify Yes or No		14. Race - Ame	rican Indian, Black,
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fter d		3 Widowed 4 Di	orced If Ye		2 (1)	.0	1	Yes 2X	No	specify:				Specify: B.	lack
ours a atura	g S	15. Decedent's Education (Spe	cify only hi	ghest grade	complete	d) 16a.		t's Usual O					16b.	Kind of Business	/Industry
72 h	뺼[Elementary/Secondary (0-12)		College (1-4	ог 5+)		during in	DS(O) WOIK	ng me. i	00 1101 4	ise reare	٥,			
vithin ere.	ompleted	12 years	l				Nurs	e	 				1	Private	e
Hyge doth	ပေျ	17. Father's Name (First, Middle							1			First, Middle,	маіде	n Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. The revent, the Medica	e Be	Charlie Gilcl 19a. Informant's Name/Relation		Print \		110	h Mailine	Address	/Street			larper	mher i	City or Town, Stat	e Zin Code)
MD 2 d 2 shoul th and N n 27 is m	۲I			,	4600									, MD 207	
and 2 and 2 ealth tem 2 traun	ŀ	Bernard Gilcl 20a. Method of Disposition	irist	- bro	ther 2			ition (Name				Date		Location - City o	
altimore, mit. Pages l ar partment of Hee portant: If ite	1	1 X Burial 2 Cremation	n 3 🗌 F	Removal fron				ner place)			_	2.			
timent tranti	1	4 Donation 5 Other 5	pacify:		L:	incol	n Me	m. Ce	mete	ery	June	26, 2	2008	Suit1	and, MD
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service	10	n Cr.	+1	M								ral Home	
Physician	\dashv	23a Part I. Enter the disease, o	complicati	ons that cau	sed the d	eath. Do n	ot enter t	ne mode of	Oying, s	uch as ca	rdiac or i	respiratory ar	rest, s	ngton, Do	Approximate Interval
/Medical	- [failure. List only one cause	on each li	ne.											Between Onset and Death
-xaminer	- 1	Immediate Cause (Final diseas or condition resulting in death)		to (or as a c								perter	151	/e	-
12.1	-	Sequentially list conditions,	b.			,- C	arur	ovasc	итаг	. uis	case				
	힐	if any, leading to immediate cause. Enter Underlying Cause		to (or as a c	onsequen	ce of):									
12.	Examiner	(Disease or injury that initiated events resulting in death) Last	С	to (or as a c	onsequen	ice of):			_		_		_		
The me of	<u>ŭ</u>	events resulting in death) cast	d.	`											
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tal Records, P.O. Box 68760, cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit	ğ.	IF FEMALE:	2	3c. If yes, ou	tcome of	pregnancy	01 /	/ 11/0	0 11				2	3d. Date of delive	ery
6876(certificate nding phy	an/Me	23b. Was decedent pregnant in past 12 months?	he 1	Live bir			2 Fe	tal death	3	Ectopic	pregnan	су		Month	Day Year
Box (e death or the attenued for use	()	1 Yes 2 ✔ No 9 Ui	iknown g		nt at time	of death	5 01	her (Speci	fy)						
the de	Physic	Part II. Other significant cond				not resultin	na in the i	underlyina	cause di	iven in Par	rt I.	23e. Did	tobacc	o use contribute t	o the cause of death?
P.O.	۾	•		.			5	, ,	Ü			1 _ Y	es 2	No 3 Pr	obably 4 🗹 Unknown
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SOTC law re has be 2 sho	톍												opsy formed		completion of cause of
Rec The Tree	悥											1 Yes	2	No 1 🗸	Yes 2 No
of Vital Records, ag Physician: The law requir After this certificate has been s neral director, page 2 should	Be	25. Was case referred to medic examiner?	Hosp	ital:					····	of Death (7		
F Vit Physic or this	ျ	1 ✓ Yes 2 No			patient 2		Outpatient Time of			y at Work	,	Home 5		dence 6 Oth	er: Scene
n of ding Ph	崩	27. Manner of Death 1 X Natural 5 Per	- 4	28a, Date of (Month, D	r injury Day,Year)	200	. Time or	injury 2		es 2	- 1	zou. Describe	e now i	rijury occurred	
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Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	Medical	(Check only Certifying	hysician: aminer:On	the basis of	ot my kno examinat	wiedge, de ion and/or	investiga	tion, in my	ume, ga opinion,	death occ	ce, and c curred at	the time, dat	e and	and manner as st place, and due to	the cause(s)
To the within To the comple	Jed Jed	29b. Signature and title of certif	and	manner sta						number				d. Date signed (N	
	-	-/ /		4	/				O.C.N	0	CME			ne 18, 2008	
		7 Moders	M.		257	14 M	w								
		30. Name and address of person Theodore M. King, Ji		oleted cause Assistar			niner	111 Pe	nn Str	eet, Bal	Itimore	, MD 2120	01		
Sta	10	31. Date filed (Month, Day, Year		460	istrar's 🦠		200	2							
Registr		JUN 2 5 20		A Paris	, St	Ken	341								

Please Type or Print in Black Indelible Ink. Er	nsure All Copies Are Legible.							
State of Maryland / Department of Health and Mental Hygiene								
Certificate of Dea	ath Reg. No. 2008							
irst, Middle, Last)	2. Date of Death							

		For State Registrar		State o	of Ma	-		nent of Ho Cate of E	ealth and N Death		giene Reg. No.	20	N 8	20	627
-3.5		1. Decedent's Nan	ne (First, Middle	, Last)						2. Date of De				3. Time of De	
Physici /Medic		Jins	Gen	Guo						June	€ 5		08	02:40	PM
Examin				, give street and nu	mber)		4b.	City, Town, or	Location of Death			County of E			
			lagett Fa			4 1-16-4	4- \	Under 1 Year	If Under 24 Hrs.	Lo Bata (B)		Movitgo			
Funeral		5. Social Security (6. Sex 1 M 2 ☐ F	7. Age	(In yrs. last birtho	Mo	onths Days	Hours Min.	8. Date of Bir (Month, Da	ay, Year)		Country		
Director	ŀ	Usual Residence				70				February	y 28,1	.938		China	
yland now at		10a. State	10b. County			10c. City, Town o	r Locatio	n					100	1. Inside City	
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er der items ner m	Funeral	11. Marital Status	or Mani	12. Was Dec	orces?		13. Was If Yes	Decedent of His s, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - A Black, V			
ours after death with the Marylan ral", or Items 23a or 28a-f show Examiner must be notified at	by F	_	rried 2 Marri 4 Divorced	ed 1 ☐ Yes If Yes, G Year or D	ive		Specify: Asian								
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12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Me	유			Jidi Guo		1401.1	A - 111 A	43		Tzehwa	Chu	- T OI-	. 7:- 0	No. of a 1	
12sh hand 7isn traun		19a. Informant's N					_		and Number or Ru					ioae)	
1 and Health		20a. Method of Dis	ky Guo -	Wife		20b. Place of D	isposition	(Name of		Date Date		cation - City		n, State	
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The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decede	ent pregnant	23c. If yes, ou		of pregnancy 2 D Fetal death	2 □Ect	opic pregnancy			2	23d. Date of			
deat deatte	sicia	in the past 1	2 □ No		nant at 1	time of death		ner (specify)				Month		ay Ye	ear
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e law has b	Completed									24a. Was		24b. Wer prio dea	e autop: r to com	sy findings av pletion of cau	vailable use of
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To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director. After the completely filled in by the funeral	ledical (29a. Certifier (Check only one)		g Physician: To th Examiner: On the and ma		examination and/									
To th within To th comp	Me	29b. Signature an	nd title of certific					29c. License	number		29d. Dat	te signed (A	Nonth, D	ay, Year)	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2008 MAY 19 BAYLI GALLEW 10:39 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 19,2008 Maryland 9. Birthplace (State or Foreign **Funeral** 1□M 2**∑**F Months Days none Director 35 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at 28a-f shov VA. Prince William Woodbridge 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15738 Pierre Court 22193 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2□ No <u>م</u> White If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced naturai Panama Completed other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee. none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Keith Gallew Ivett Montout 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Gallew/Father 15738 Pierre Court Woodbridge, Va. 22193 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ■ Removal from State 5/28/2008 Troy, PA. Oak Hill Cem. ≱ ⊟ Other (*Specify*) 21. Signature of neral Service Lice PHILIP TO SERVICE, P.A. 10 9241 Colimbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PREMATURITY /Medical Due to (or as a consequence of): **Examiner** TRISOMY 18 Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【XNo 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 2 ₩ No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 1 🕅 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 Yes 2 No after death.

I Director: A
d in by the for 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-41551may 21 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600 RUSSELL R. MOORES MC_ COL USA gistrar's Signature 31. Date filed (Month, Day, Year) State JUN 10 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** WILFREDO 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and no 4c. County of Deat Examiner The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 XXM 2 □ F NONE Ĩ970 37 Nicaragua Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f shov Examiner must be notified at Director 1 X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 6 death with 280 Longford Drive 23a 21702 Funeral Nicaragua items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: ь 1 Never Married 2 Married 2 XNo Maryland 21215-0036 Specify: Nicaraguan 1 X Yes 2 ☐ No Specify: White er than "natural", c , the Medical Exam ģ 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. 12 Carpet Specialist Self-Employed marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be and Mental Alejandro Garcia Sodelba Cerda ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8 Martha Garcia / Wife 280 Longford Dr. Frederick, MD 21702 Health tem 27 i Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Pages 1
Department of Hi
Important: If iter
any Injury or oth Date 20c Location - City or Town, State cometer, crematory or other place)
Resthaven
Memorial Gardens 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State June 10, 4 ☐ Donation _5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Lineau e Rësthavende Puffetal Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disea shock, or beart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only one cause on each line Immediate use (Fin disease or condition resulting in death) **Physician** movira Weeks /Medical Due to (or as a consequence Examiner was tinibe list eventition Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of attending physician and d for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) ed by the at detached f 2 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 90 4 Unknown 1 🗌 Yes 2 No 3 Probably Completed 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page No. 1 🗌 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 🗆 DOA ည this funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I Director: After the in by the funeral Certification: or Attending 1XX Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident after death. 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) filled in within 24 hours of To the Funeral I To the Hospital 29a. Certifier Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 2008

DHMH 17 Rev 1/2001

State

Registrar

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AKIL MERCHANI

2008

32. Registrar's Signature

31. Date filed (Month, Day, Year)

JUN 1

			For State Registrar	State of Mary	-	artment of H rtificate of I		Mental Hy	giene Reg. No. 2	800	20630	
	Physici /Medic		1. Decedent's Name (First, Middle, Las Mary McIntyre H	*				2. Date of De June		2008	3. Time of Death 1:57 P M	
1	Examir		4a. Facility Name (If not institution, give Spa Creek Center			4b. City, Town, or Annapo	lis		Ann	nty of Death e Arun		
	Funeral Director		5. Social Security Number 095–20–4384 6. Solution 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, Year)		place (State or Foreign htry) York	
	Maryland a-f show ified at	ctor	10a. State MD 10b. County Anne Aru	_	City, Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2 ▼No	
	th with the 23a or 28 ist be not	al Dire	10e. Street and Number 694 White Swan	Drive		10f. Zip Code 2101	2		10g. Citizen o		ntry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 💢 No	ispanic Origin? (! an, Mexican, Pue Specify:	Specity Yes or No rto Rican, etc.)		Race - Americ Black, White, cify: Wh		
Maryland 21215-0036	within 72 ho jene. than "natur the Medical I	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager					_{dustry} zer Office	
land 2	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mec	To Be C	17. Father's Name (First, Middle, Last) Alec B. McIntyre					me (First, Middle eth Dors		name)		
	ss 1 and 2 sho of Health and I item 27 is ma other trauma		19a. Informant's Name/Relationship (Tandy Wilson/dau	ighter	1030	ng Address (Street) Stoning	ton Driv	e Arnold	a, MD 2	1012		
Baltimore,	Pages 1 ment of Ha ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Denation 5 ☐ Other (Specify	Hernoval from State	Metro Ci		20	e 12, 08	Baltim		Maryland	
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licknese 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Fun 495 Gov. Ritchie Hwy, Severna Park, MD									
8760,	Cate be executed hysician and physician and the buriat-transit the buriat-transit	dical Examiner	26a. Part Lenter the disease, of complete shock or heart failure. List only immediate Cause (Final disease of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cord) Due to (or as a cord)	nsequence of):	cere h.	rad He	mor	Ng.		Approximate Interval Between Onser and Beath	
P.O. Box 6	The law requires that the death certific that has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ □ o 9 □ Unknown	23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	/		23d. Date of delive Month		ery Day Year	
	juires that n signed by	þ	Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.		tobacco use co Yes 2 ⊘kb io		he cause of death?	
Division or Vital Records,	2 38	Completed						24a. Was auto perf 1∐ Yes		prior to co death?	opsy findings available empletion of cause of 2 ☐ No	
Vita	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatier	nt 3 DOA Oth		eath <i>(Ch</i> eck o <i>nly</i> Home 5□ Res		Other (Specia	f _V)	
ion or	fing After fune	ation: T	27. Manner of Death T☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. Injur Wor		28d. Describe			97	
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (S	pecify)			City or To	wn, State)		al Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in It	edical	29a. Certifier (Check only one) Check only one)	yslcian: To the best of my niner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death oc	ce, and due to the curred at the time	e cause(s) and , date and plac	manner as s ce, and due t	stated. to the cause(s)	
	withi To t	Ň	29b. Signature and title of Certifier	CML			2036		29d. Date sig	4001	D	
0	#12		30. Name and address of person who	completed cause of death		Print)	True	Chuh	, Ma,	2/41	S	
C. Carlo	Sta		31. Date filed (Month, Day, Year)	32. Registrar's \$	Signature	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens

	1		For State Registrar	State of Ma	aryland /	Cer	tificate of l	leaith an Death	a Meritai H	ygierie Reg. No	2008	206	31
_	Physicia	an	1. Decedent's Name (First, Middle	,					2. Date of D	D -	.008 Year	3. Time of	
	/Medic	al	Elizabeth Gera: 4a. Facility Name (If not institution		wer		4b. City, Town, or	Location of D			. County of Death	8:45	Рм
	Examin	er	Heartland of Add				Adelphi		oun		ntgomery		
	Funeral		5. Social Security Number		e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date of E	Birth Day, Year,	9. Birth	nplace (State o	r Foreign
-a/	Director	Š	579-20-9206 Usual Residence of Decedent	1□M 2 \ \(\overline{X}\) F 8		113.			Augus	t 27,	1925 Wa	shingt	onDC
	ryland rhow	_	10a. State 10b. County		10c. City, T					_		10d. Inside Cit	·
	he Ma 28a-f s otifiec	Director	DC 10e. Street and Number		Washi	ngto	10f. Zip Code			10g Ci	Yes 2 No Citizen of What Country?		
	3a or 3			ATT 7			20001			USA	uzen or what oot	may.	
	ems 2	Funeral	946 T. Street, 11. Marital Status	12, Was Decedent I	Ever in U.S.	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin' an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)		14. Race - Amer Black, White		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If of Health and Mental Hygiene. If of Health and Mental Hygiene. If other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	by Fu	14 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 □ Yes 2 1 1 N If Yes, Give Year or Dates:	10	i i	□Yes 2 No	Specify:			Specify: B	lack	
1215-0036	72 hou natura ical E	ted	15. Decedent (Specify only highes		1	6a. Deced	ent's Usual Occup	ation	working	16b. Kind of Business/Industry			
121	vithin 7 ine. ihan "r ie Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) 1	ibra:	kind of work done o OO NOT use retired rian	i)	Working	Gov	vernment		
N	filed v Hygie other t ent, th	ပ္ပ	17. Father's Name (First, Middle,			JIDIA.	LIGH	18. Mother's	Name (First, Midd			/	
Ian	Duld be Mental arked o	To Be	Richard A. High	tower		·-		Nora T	homas				
Maryland	12 should and Mer Is marke raumatic	ľ	19a. Informant's Name/Relationsh				g Address (Street						
	thand Health tem 27 other to	. 6	Candace Selwyn/1 20a. Method of Disposition	Niece	20b. Place		Beekman R sition (Name of natory or other place		Date Date	1	ocation - City or		
ō E	Pages nent of I int; If its iny or o		1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (<i>S</i> i				emetery		ne 9,200	8 Sui	tland. N	Marvlan	d
Battimore,	permit. Page Department of Important; If any Injury of once.		21. Signature of Funeral Service	Licensee	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	22	. Name and Addre	ss of Facility	McGuire	Funer	al Servi	ice,Inc	•
Des o	<u> </u>		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. [740 Do not ente	00 Georgi	.a Aven	ue,Washii rdiac or respiratory	ngtor arrest.	,DC 2001	Approximat	e
1	Physician		Immediate Cause (Final	only one cause on each lin	P. Dun	out	MONAR	4 A6	REST	,	1	Interval Bet Onset and	ween Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequen		1.47						
	Examiner	io.	Sequentially list conditions,	b. Due to (or as	a consequen	ice of):	H M	MXC	1104				
5	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	se se	PTIC	CN	MA						4
Ď,	icate be executed physician and s the burial-transit	I Exa	resulting in death) Last	Due to (or as	a consequen	ice of):	,						
68/60,	ficate by physic s the b	edical	W	d									
Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome]Ectopic pregnancy	,			23d. Date of deli		
о В	ie deat the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2X No 9 ☐ Unknown	4□Pregnant at 9□Unknown			Other (specify)			-	Month	Day	Year
ב	uires that the de signed by the a Id be detached I		Part II. Other significant condition	ons contributing to death be	ut not resultir	ng in the ur	nderlying cause giv	en in Part I.	23e. Di	d tobacco	use contribute to	the cause of	death?
rds	w requires been sign should be	ed by				_			1[]Yes 2	2 □ No 3 □ Pro	obably 4 🔀	Unknown
eco o	aw s b	Completed							24a. W	topsy	prior to o	topsy findings	available ause of
Vital Records,									1□ Yes		death? o 1 ☐ Yes	2 ⊠ No	
	ysicial is certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatie	ent 2∐ER	/Outpatien	t 3 DOA Oth	or:	Death (Check onl ng Home 5 ☐ Re		6 □Other (Spec	cify)	
n or	ding Phys n. After this funeral di	on: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28 y Year)	3b. Time of Injury	Wor	y at k?	28d. Describ				
DIVISION	uttendi death. ctor: A y the fu	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	pation and the second initial second initial second in the second initial second in the second initial second in the second in t	urv - At home	e. farm. str	M 1 □ eet, factory, office	Yes 2 □ No		(Street a	and Number or Ru	ıral Route Nur	nber,
2	al or Atten s after death al Director: ed in by the	Certification:	4 ☐ Homicide determ	building, et	c."(Specify)					Tòwn, Sta			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,			g Physician: To the best Examiner: On the basis o	f examination						nd place, and due	to the cause(
	o the	Medical	29b. Signature and title of certifier	and manner sta	ated.		29c. Licens	e number		29d. D	ate signed (Monti	h, Day, Year)	
	Q		1 Doyens	LA MD			14	652c	1	Ju	NE 4 2	800.	
	0		30. Name and address of person	who completed cause of d	eath (Item 23	3a) (Type	Print)	000	Knav /	DEC	ate signed (Mont NE 4 2 NECUT M	APVIA	1 222
200	Sta	te	31. Date filed (Month, Day, Year)	P. Registr	ar's Signatur	e 🚜	NI COVE	VIND	7007	MICO	, ADCO (/(I	ग ।पावस	100770
	Registi		JUN 112	008 January	J.	Span	les .						

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: this After t 24 hours after death Funeral Director:

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ___atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29c. License number 29d. Date signed, (Month, Day, Year)

E3 State Registrar

Certification: To

Medical

291. Signature and ble of certifier

Hofmann, MD

JUN 12 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30434 Mt. Vernon Road, Princess Anne, MD 32. Revistrar's Signature

within 24

21853

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Harding May 31, 2008 12:50 a^M Richard William /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Casey House Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 1⊠M 2□F Director 578-54-3406 67 Feb. 21, 1941 Washington, DC Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2\X\No Directo **M**aryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 13115 Bluhill Road 20906 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than ' Elementary/Secondary (0-12) College (1-4or 5+) None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 77 is marked c Chester Arthur Harding Dorothy Luciel Harding-Coberth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a important: If item 27 is any injury or other trau once. 802 Roxboro Road, Rockville, MD 20850-3820
Date 20c. Location - City or Town, State Catherine Sessoms-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery June 6,08 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Sign, tur, of Fun I Servi & Acense, 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as attending for use as IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown been sig Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? page certificate 2□ No 1□ Yes 2X No 1 TYes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospice 1 🔲 Inpatient P 1 Yes 2 No 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After (Month, Day Year) Injury 1X Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal

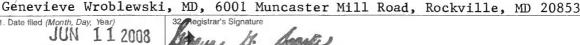
P.O. Box 68760 Division or Vital Records, To the Hospital

> State Registrar

31. Date filed (Month, Day, Year) JUN 11 2008

(Check 9

29b. Signature and title of certifier



W

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Doo64615

29d. Date signed (Month, Day, Year)

6/3/2008

		1 - For State Registrar	State of Marylar		artment of H rtificate of I			giene Reg. No. ? () (18 2063		
Physic		Decedent's Name (First, Middle, Last, Agnes		Holler			2. Date of Dea Month JUNE	Day Y	3. Time of Death Year 2:40 A		
/Med Exam Funera	iner	4a. Facility Name (If not institution, give MEMORIAL HOSPITAL 5. Social Security Number 6. Se	x 7. Age (In yrs.			RLAND If Under 24 Hrs. Hours Min.	8. Date of Birt	h v, Year)	f Death EGANY 9. Birthplace (State or Foreig Country)		
Director works tat		234-38-8114 Usual Residence of Decedent 10a. State 10b. County WV Minera	10c. Ci	ty, Town or Lo			Jul 2, 1	1924	10d. Inside City Limit		
with the Ma a or 28a-f s t be notified	Director	10e. Street and Number Rt. 3 Box 277	Ш	TXIQ	10f. Zip Code	26753		10g. Citizen of Wh	nat Country?		
laryland 21215-UU36 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ X lo	lispanic Origin? (Sp an, Mexican, Puerto Specity:	pecify Yes or No- Prican, etc.)	r No-) 14. Race - American Indian, Black, White, etc. Specify: white			
d Z1Z15-UU36 filed within 72 hours af Hygiene. other than "natural", or ent, the Medical Exami	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work d)		own hon	ne		
ed ala Be	To Be	17. Father's Name (First, Middle, Last) Solomon Robis 19a. Informant's Name/Relationship (Ti		10h Maili	ng Address (Street	Bertha	Name (First, Middle, Maiden Surname) ha Kaylor Robison r Bural Boute Number, City or Town, State, Zip Code)				
IOCE, Maryle ges 1 and 2 should tt of Health and Mer If item 27 is marke or other traumatic		Robert Holler 20a. Method of Disposition	husband	Rt.	3 Box 27	7	Ridg	eley	WV 26753		
Baltimore, Mi permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funral, engice cons	Removal from State	rt Ashby	matory or other plac Cemetery		6/20/2008	Fort As			
Physiciar /Medica Examine		23a. Part Lenter me disease, or comp shock, or heart failure. List only of Immediate C rise (Final disease or co dition resulting in de th)	a. <u>CARDIAC ARE</u> Due to (or as a conse	ath. Do not en	108 Virg	ginia Avenue:	Cumberla		Approximate Interval Between Onset and Death		
icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Ent of user this cause (Disease or injury that initiated events resulting in death) Last b. SEPSIS Due to (or as a consequence of): C. URINARY TRACT INFECTION Due to (or as a consequence of): d.									
I HECOTGS, P.O. BOX 61 The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as!	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregi 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3[⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date Mon	e of delivery th Day Year		
COTGS, P. w requires that the bear signed by should be deta		Part II. Other significant conditions of DEMENTIA SMALL	nontributing to death but not re		inderlying cause gh	ven in Part I.	1 Yes 2 No 3 Probably 4 Unk				
	e Completed by	25. Was case referred to medical				26. Place of Dea	7 2 2 2 2	psy promed? de 2 X No 1	Vere autopsy findings availat rior to completion of cause o eath? □ Yes 2 No		
Or VITa Physiclan: r this certific ral director,	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2[ER/Outpatie	III 3 DOA		1	idence 6 □Othe			
Vision Attending r death. ector: Afte by the fune	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	(Month, Day Year)	Injury home, farm, st	M 1]Yes 2□No	28f. Location (er or Rural Route Number,		
the Hospital or nin 24 hours afte the Funeral Dir	ledical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examinand manner stated.	nowledge, dea	th occurred at the to	ime, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) and mar , date and place, a	nner as stated. and due to the cause(s)		
To the within To the Compl	Me	29b. Signature and title of certifier	Cach	m	29c. Licens	se number		29d. Date signed JUNE 18,	(Month, Day, Year)		
	State		completed cause of death (Ite	IEMORIA		CUMBERLANI	D, MD	21502			

State of Maryland / Department of Health and Mental Hygiene 20635 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 08:55 AM Irwin June 2008 Hamilton 4 8 1 Leroy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil 23 Westover Place North East If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days **Funeral** Hours **X**XM 2□ F July 21, 1940 Maryland Director 213-38-6585 67 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes 2X No North East Maryland Cecil Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21901 United States 23 Westover Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White altimore, Maryland 21215-0036 1 ☐ Yes 2**XX**No Specify. ۵ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Concrete Construction 12 Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Emma May Hamilton Unknown ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23 Westover Place, North East, Maryland Penny Hamilton / Wife 20b. Place of Disposition (Name of Cilpin Manor Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition June Daie 4. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4☐Donation 5☐Other (Specify) Elkton, Maryland 22. Name and Address of Facility Crouch Funeral Home 21. Signature of File and S 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) confetre **Physician** in known /Medical Due to (or as a consequence of) **Examiner** COPP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Dials Hospital or Attending Physician; The law requires that the death certificate be executed nelles the burial-trar Due to (or as a consequence of): P.O. Box 68760. physician Slog for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes 2 No 1□ Yes 25. Was case referred to medical examiner? director. 26. Place of Death Check onl one Other: 4 Nursing Home Nesidence 6 Other (Specify)

Injury at 28d. Describe how injury occurred 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours after To the Funeral Dire completely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mais 80, CHIH HIM 31. Date filed (Month, Day, Year) **JUN 1 1 2008** 32. B State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2008 19 Helen Mae Hoffman June 6:15 a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1 Locust Road Harford Aberdeen 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/30//1925 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 DE 412-28-4578 83 Director Tennessee Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Harford Aberdeen 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1 Locust Road 21001 U.S.A. Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Retail Sales permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other I any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Judd Hamilton Elizabeth Chase 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Hoffman (Spouse) 1 Locust Road Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R. A. Ferris & Co. 6/20/08 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Tarring-Cargo Funeral Home Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resiliatory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, that, reading to infine diatacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or de a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 pronths? 1 ☐ Yes 2 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 HInknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♠ No autopsy perform certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Yes 20 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760, or Attending Physician; To the Hospital

offmen. HERD M

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) JUN 2 5 2008

30. Name

(Check only one)

29b. Signature and title of certifier

and address of person wh

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	Cei	rtificate of I		R	eg. No. 2 ()	08	201	637	
Phys		1. Decedent's Name (First, Middle, Last) Lorraine G. Jones				2. Date of Deat Month June		Year 008	3. Time of 4:30	Death P M	
l /Me Exan	dical niner	4a. Facility Name (If not institution, give street and number) Crofton Convalescent Cente	er	-	Location of Death						
Funer Directo	_	219–10–8139 1□ M 2X F	(In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 6,					
e Maryland la-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Queen Annes	10c. City, Town or Lo	ocation 10d. Inside City Limit 1 Yes 200							
th with th	al Dire	10e. Street and Number 110 Davidson Drive		10f. Zip Code	21666	1	0g. Citizen of \	What Coun	try?		
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, its Modical Explicit inset to insetting at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Never Married If Yes, Give Year or Dates:	0	Was Decedent of H fYes, specify Cuba I∐Yes 2. Maria No	ispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	ck, White, e	American Indian, White, etc. White			
1215-C ithin 72 ho ne. han "natu Modical	mpletec	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	(Give	dent's Usual Occup kind of work done o DO NOT use retired Secretary	during most of workin i)	ng	16b. Kind of Bo Board o			1	
Maryland 21215-0036 to 2 should be filed within 72 hours aft the and Mental Hygiene. Zz is marked other than "natural", or traumatic event, ir a Modical Examination.	a	17. Father's Name (First, Middle, Last) William Howard Busch		Secretary	18. Mother's Name Georgine	(First, Middle, I	Maiden Surnan		Cacioi	1	
'e, Marylar 1 and 2 should be Health and Menta em 27 is marked other traumatic ev	P	19a. Informant's Name/Relationship (Type. Print) Kirsten Mirack/friend/execu	ntor 19b. Mailin	g Address (Street Davidson	and Number or Rura Drive S	I Route Number	; City or Town, ille, M	State, Zip aryla	Code) nd 21	1666	
timor t. Pages rtment of rtant: If it	once.	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature 1 Juneral Service Licensee	/2008 1 nn M. Ta	aylor F	re, M unera	orTown, State , Maryland eral Home is, MD 21401					
68760, tificate be executed Band Illinoise and Illinoise as the burial-transit as the burial-transit	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each linguistic cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause (Enter Undertying Cause, Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
. Box (death certification) death certification death certification death certification death de	Physician/Medical	d	Ectopic pregnanc	у		23d. Date of delivery Month Day Year					
cords, P. w requires that to be been signed by should be detacted.	5	Part II. Other significant conditions contributing to death but	not resulting in the un	nderlying cause give	en in Part I.		bacco use cont es 2 □ No				
IRe The la ate has	Completed	Deweli	2			24a. Was a autops perform 1 □ Yes	med2_	Were auto prior to co death? 1 □ Yes	osy findings and pletion of ca	available ause of	
f Vital Re ysician: The last certificate ha	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo Hospital: 1 ☐ Inpatier		Oth	26. Place of Death	(Check only on	e)				
VISION Of VITA Attending Physician: r death. ector: After this certific by the funeral director,	ion: To	27. Manne of Death Natural 5 Pending 28a. Date of Injury (Month, Day)	nt 2 ER/Outpatien y 28b. Time of Injury	28c. Injur Worl	er: 4 Nursing Hon y at (? Yes 2 No	ne 5∐ Reside 28d. Describe ho			<u>/)</u>		
Division of ail or Attending Phy s after death. I Director: After this od in by the funeral d	Certification: To	2 □ Suiside 6 □ Could not be	ry - At home, farm, stre (Specify)			28f. Location (Si City or Town	on (Street and Number or Rural Route Number, Town, State)				
DIVIS To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of Examiner: On the basis of and manner state.	examination and/or in)	
To t with To t	Σ	29b. Signature and title of pertitier		29c. Licens		2	9d. Date signe				
		30. Name and address of person who completed cause of de	ath (Item 23a) (Type,		57023 #231 Ar	mapali	5 mi		1401		
S Regi	State strar	31. Date filed (Month, Day, Year) JUN 1 0 2008 Registra	r's Signature	de		V					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04671 State of Maryland / Department of Health and Mental Hygiene Harry Khosrofian 2008 20638 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ June 16, 2008 1530 hrs Khosrofian **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silverspring Holy Cross 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (in vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Min. 579-26-3425 Director Dec. 12, 1924 Country) New York 1^X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. Count 10c. City. Town or Location 1 Yes 2 No hours after death with the Maryland Maryland Montgomery Silver Spring Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 2405 Churchill Road 23a Funeral 14. Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Married Yes Widowed 4 Divorced If Yes. Give Yea Yes 2 X No specify: Specify. White <u>≽</u> Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked and injury or other Elementary/Secondary (0-12) 72 General Services Technical Engineer Administration 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Khosrof John Khosrofian Makroohi Arakelian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Khosrofian/Brother 2204 Seminary Road, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition June 19 crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2008 Rockville, Maryland b Donation 5 Other Specify: Parklawn Memorial Park 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval (I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED 23a, PII, 27, perME, g882, 8/26/08 TT X UNPENDED e attending physician for use as the burial -To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buria Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Yes 2 No 3 Probably 4 Unknown Pneumonia Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed 2 No Yes 2 1 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ✓ Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number 29b Signature and title of cortifier O.C.M.E. Name and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

16 263.1

State Registrar

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

June 18, 2008

31. Date filed (Mod / Dby, Year)

State of Maryland / Department of Health and Mental Hygiene 20639 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JÜne 6, KAHN 2008 Rita 9:15 A. [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 8100 Connecticut Ave. #1507 Chevy Chase If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Oct.9, Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) Funeral 1 □ M 2 💢 F Germany 131-14-0348 82 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director MD Chevy Chase Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with Connecticut Ave. #1507 20815 U.S.A. death v Funeral 8100 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဤ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Š Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Accounting Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Jacob Flora Stein ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7421 Baltimore Ave.,, Takoma Park, MD 20912 19a. Informant's Name/Relationship (Type. Print) Linda Kahn / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Cedar Park Cemetery** June 11, 2008 Paramus, New Jersey Torchinsky Hebrew Funeral Home 22. Name and Address of Facility 21. Signature of Furt rel Service Lic 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non small cell lung cancer 3 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending g IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a detached i 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Neuropathy Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No certificate | 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Injury Hospital or Attending 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29c. License number D35996 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 June 9, 2008 0 1 mg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2730 University Blvd. w, #400, Wheaton, MD 20902 <u>Linda Burrell, MD,</u> 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 1 0 2008

State of Maryland / Department of Health and Mental Hygiene 2008 20640 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 240 AM KINCARO 2008 MAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min Illinois **№** M 2 □ F Nov 8, 1925 82 Director 319 28 2983 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Medical Examiner must be molffied at 1 ☐ Yes 2 No Howard MD Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 5199 Columbia Road 21044-5508 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 **∑X** es 2 □ No If Yes, Give Year or Dates: **1942-45** 10 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Commercial Real Estate Agent Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Mae Painter John Kennedy Kincaid ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 is other tra 5199 Columbia Road Columbia, MD 21044-5508 Barbara J. Kincaid/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Natl. Cem. 7-11-2008 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Dow Collins With 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final INCOPE Hours **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 100 3 Probably 4 Unknown MORKIN 1 ☐ Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Mort s certificate has be irector, page 2 sl autopsy performs 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation nours after death.

neral Director: Aft
y filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 8+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EGn 55 Berlin Donald ND 31. Date filed (Month, Da gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registra MEND#26 per MD, 6-11-08, BW, MOD Registra MEND#25, 24 per MD, 6-11-08, BW, MOD Reg. No. 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 9, 2008 **Physician** 8:41 а м Mary Ellen Kenney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgamer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Sex **Funeral** Hours Months Days Min 1 □ M 2 🛣 F Yrs. 214-34-7122 72 March 31, Director 1936 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 1 ☐ Yes 2 ₩No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? TISA 16801 George Washington Drive 20853 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Payroll Personnel Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Sidney Wenk Edna Penn 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Linda Hall/Daughter 510 Chippingwood Drive, Port Republic, MD 20676 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June ■ Burial 2 Cremation 3 Removal from State Parklawn Memorial Park 2008 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) many years **Physician** hronic obstructi /Medicai Due to (or as a consequence of) Examiner smoking if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Exami physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) signed by the a 1 □Yes 2 DNo 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Xes 2 🗌 No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the irector, page 2 st autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home -5 Tospital: 2 ☐ No Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA denee 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death.

I Director: A:
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limit Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0 CT y 021057 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar NAH TRIVIOL

1 1 2008

31. Date filed (Month, Day,

JUN

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6/19/2008Joan Elizabeth Wagner Lewis 12:00 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Talbot Hospice Foundation Talbot Easton If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 3/26/1939 9. Birthplace (State or Foreign Country)
Ohio Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗹 F Days Hours Months 300-34-5134 Director 69 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at of Health and Mental Hygiene.
If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 722 Mecklenburg Ave. 21601 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No White þ Specify 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Adolph Wagner Helen May Dye P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3651 Veazey St., NW Washington, DC 20008 Diane Heath/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mid Shore Cremation Center 6/20/2008 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 21. Sanature of Funeral Service Licensee 22. Name and Address of Facility Mid Shore Cremation Center, 2272 Hudson Rd., Cambridge, MD 21613 excel ence Approximate Interval Between Onset and Death 3a, Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filting. List only one cause on each line. Immediate Cause (Final **Physician** 8mos disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate class. Englished to the class of class (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed Yes 2 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No ၉ 1 | Inpatient 2 ER/Outpatient 3 DOA After this 6-DOther (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division or Vital Records, P.O. Box 68760, ō Hospital

nours after death.

neral Director: A
filled in by the fu within 24 hours a

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DHMH 17 Rev 1/2001

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David H. Smith, M.D., 8221 Teal Dr., Suite 302 Easton, MD 21601

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29b. Signature and title of qertifier

29a. Certifier

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of	Marylan		artment of H rtificate of I			giene Reg. No. '	2000	2061	. 2
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	1 and Healt em 2		KARRIE Y. TAN/GRAND 20a. Method of Disposition	DAUGHTER	20b. P	lace of Dispo	GALT AVENUE		SPRING, MA Date		0 20902 cation - City or To	own, State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		1 X Burial 2 ☐ Cremation		itate	-	matory or other plac	1			•		
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Baltimore,	ages int of l		1 ☐ Burial 2 🏋 Cremation 3				sition (Name of matory or other place Cremato	1	2008		wark, Del	
Ē	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Special Service)		Hay		2. Name and Addre			_ /		aware
B	permit. Departr Importa any inju		What he									ry1and21901
	1151		23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications that caused	d the death	. Do not ent	er the mode of dyi	ng, such as ca	ardiac or respirato	ry arrest,		Approximate Interval Between
V.	Physician		Immediate Cause (Final disease or condition	CA	VON	ony	graten	4)	recos	0		Onset and Death UNKNWN
	/Medical		resulting in death)	Due to (or as	a consequ	ence of:		1	-			20.10
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9	tificat ig phy as th											
Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	v			23d. Date of deliv	
В	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me	in the past 12 months? 1 \(\sum \) Yes 2 \(\sum \) No	4□Pregnant a 9□Unknown			Other (specify) _				Month	Day Year
P.O.	that the de ned by the a detached t	Phy	9 ☐ Unknown Part II. Other significant conditions	s contributing to death h	out not resu	Iting in the u	nderlying cause giv	en in Part I	23e.	Did tohacc	o use contribute to	the cause of death?
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0 [ng Pt fter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year)	28b. Time o Injury	f 28c. Inju Wo	ry at rk?	28d. Desc	ibe how in	njury occurred	
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Division or Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	4 ☐ Homicide determine	ad Zoe. Flace of In	tc. (Specify	me, tarm, sti	eet, factory, office		City o	on (Street r Town, St	and Number or Ru ate)	ral Houte Number,
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	Vithir Vithir Comp	Me	29b. Signature and title of certifier				29c. Licens				Date signed (Month	-
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-			30. Name and address of person wh	no completed cause of o	death (Item			1 -2	10			
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			State of Maryland / Department / Department / Department / Department / Department / Department	artment of Health and Natificate of Death	Mental Hyg	iene _{eg. No.} 2008	20645				
	11		1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Year	3. Time of Death				
H.	Physicia /Medic		Theodore Newman McFadden, J	r.	June	18 2008	1615 P ^M				
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th				
		- 16	Union Hospital	E1kton If Under 1 Year If Under 24 Hrs.	T = - (5:::	Cecil					
Jan Se	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 116-16-5102 84 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day NOV 8,	, Year) Co	thplace (State or Foreign ountry) ryland				
	/land ow at		10a. State 10b. County 10c. City, Town or Loc	cation			10d. Inside City Limits				
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	th the or 284 e not	Directo	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	ountry?				
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	tems	Funeral	11. Manital Status 12. Was Decedent Ever in U.S. Armed Forces? World	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi					
36	rs afte	by F	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 1 ☐ Married 5 armed Forces? World 1 ☑ Yes 2 □ No 1 ☑ Yes 2 □ No 1 ☑ Yes 3 □ No 1	1 ☐ Yes 2 🎇 No Specify:		Specify:	White				
8	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	edi	15. Decedent's Education 16a. Deced	dent's Usual Occupation	Ī	16b. Kind of Business					
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50	ding J. After funer	ion	1 Natural 5 Pending (Month, Day Year) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	260. Describe fi	ow injury occurred					
Division	l or Atten after deatf Director: I in by the	Certification:	2 ☐ Actident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined 28e. Place of injury - At home, farm, streething building, etc. (Specify)		28f. Location (S City or Tow	treet and Number or Fi n, State)	tural Route Number,				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and manner stated. Check only one)	n occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the ourred at the time, o	cause(s) and manner a date and place, and du	is stated. le to the cause(s)				
	To th withii To th comp	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Mon	th, Day, Year)				
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	- Ct-	to	Rosemary Iwunze, M.D., 106 Bow Street	Elkton, MD 219	921						
	Sta Registr		31. Date filed Month, Gay Year 108								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 1312 Janice Ann McCarty June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 □ M 2**X** F 214-32-4842 March 21,1930 78 MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 □ No Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 Baptist Road 21750 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent DePaul Donegan Frances Yarnell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. McCarty, Sr./Husband 123 Baptist Road Hancock, MD 21750 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Peter's Catholic 06/20/2008 Hancock, MD 21. Signature of Funeral Service License 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) nemon Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2. No 1 ☐ Yes 2-1No 1 □ Yes

Physician /Medical **Examiner**

physician a s the burial-t

attending ph

signed by t I be detach

page 2

director

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filled in by

completely

P.O. Box 68760,

Division of Vital Records,

Physician:

To the Hospital or Attending

within 24 hours after death.

To the Funeral Director:

Examine

Completed by Physician/Medical

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Medical Certification: To

Physician

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other traumatic event,

Baltimore, Maryland 21215-0036

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Funeral

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10a. State

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? in the past 12 mon

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

Other: Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 □Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 ☐ Yes

27. Manner of Death

□ Natural

2 Accident

3 Suicide

4 Homicide

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

21 No

5 Pending

investigation

determined

6 ☐ Could not be

29c. License number 058853 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTIETAM STREET, HAGERSTOWN, MD 21740

CHOTANI HABIB

31. Date filed (Month, Day, Year) JUN 2 5 2008 251 E 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Richard Edward Michael 9, 11:10 P M June 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington 11 W. Baltimore St. Apt# 1017 Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 66 220-40-2330 Director Nov. 5, Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County at 1 XYes 2 No 28a-f sh notified Director Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Heatth and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or items or other traumatic event, the Medical Examiner must be n Apt# 1017 11 W. Baltimore St. 21740 U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify. 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Jane Kerfoot Roy E. Michael ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 183 Brynwood St. Hagerstown, Maryland 21740 Pamela M. Brubaker (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o 1 ☐ Burial 2 Tremation 3 ☐ Removal from State June 12, Smithsburg, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 AUS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath Immediate Cause (Final Physician METASTA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conse juence of Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician a the burial Box 68760. Physician/Medical attending p IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has e 2 certificate ha 1☐ Yes To the Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ 'No 1 Inpatient 2 ER/Outpatient 3 DOA After th funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours fler deal To the Funeral Director completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13424 steven 31. Date filed (Month, Day, Year) JUN 2 5 2008 32. Registrar's Sonature State Registrar

			1 - For State Registrar	State of Ma	arylanu / D	Certific	cate of L	Death		Reg. No.	2008	
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	Funeral Director		129-14-9914	Sex 1□xm 2□ F	e (In yrs. last birth 85 Y		Inder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 01/23	7192	9. Birth	nplace (State or Foreign untry) NY
	ryland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits
	he Mai 28a-f s ouified	ectol	MD Montgom 10e. Street and Number	ery	Bethes		. 7'- O- I-			10 0.11		1 ☐ Yes 2 X No
	23a or	al Dir	8110 Lilly Stone	Drive		10	f. Zip Code 20817			-	izen of What Cou SA	untry?
30	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its filed Exercitant inst be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🛣 Divorced	12. Was Decedent E Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Yes} \) If Yes, Give Year or Dates:	Ever in U.S. lo		ecedent of H specify Cuba	Ispanic Origin? (Sp n, Mexican, Puerto Specify:			14. Race - Amer Black, White Specify: Whi	, etc.
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Dall	permit. Depart Import any inj once.		21. Signature of Funeral Service Lice	nsee		Adve	ne and Addres	ss of Facility eral Serv ch, VA	vices,	7211	Lee Hig	hway
	Physician	1000	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition		the death. Do not e.	of enter the	mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	u	a consequence of		ancer					1 month
	p .t	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	a consequence of):						
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בי ומו	Physician: The law this certificate has al director, page 2 s	e Completed	25. Was case referred to medical	T				OC Plans of Pass	1 □ Yes	rmed? 2. No	prior to c death?	ompletion of cause of 2 □ No
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5	ng fte		27. Man of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day)			28c. Injury Work	yat ? Yes 2 □ No	28d. Describe	how injur	y occurred	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Certification:	3 Suicide 6 Could not be determined	e 28e Place of Inju	ry - At home, farm . (Specify)	n, street, fa			28f. Location (City or To			ral Route Number,
:	e Hospi 24 hour e Funera etely fill.	Medical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best o miner: On the basis of and manner stat	examination and/	death occu or investiga	irred at the tin ation, in my o	ne, date and place pinion, death occu	, and due to the red at the time,	cause(s date and) and manner as I place, and due	stated. to the cause(s)
	To the Vithin To the compl.	Me	29b. Signature and title of certifier		0 -	-	29c. License				te signed (Month	
	2000	1	20. Name and address of passen who	completed source of	3 4 S	una Dui-t	D	43083		Ju	ine 9,	2008
(1000	U	30. Name and address of person who	MD 9707	medica	Lec	nter D	me #30	10 Rock	wN	le, MD	20850
	Sta		31. Date filed (Month, Day, Year)	32. Jegistra	r's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 72008 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** theson June 2008 04:35AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Kark Hospital Montgomer Takoma If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 80 1□M 211 217-70-2775 Sept. 8, 1927 Jamica Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b, County 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Adelphi Itince beorge's Director Marylance 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? States 20783 united or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 Doivorced 'natural', 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retiged) Completed 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic avent Elementary/Secondary (0-12) College (1-4or 5+) 7 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 197 les Kichards layne Informant's Name/Relationship (Type, Print) Quishter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3415 Brentwood Tilden 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Deurial 2 □ Cremation 3 □ Removal from State 6/13/08 Brevitwood tort *4 ☐ Donation 5 ☐ Other (Specify) -incoln 22. Name and Address of Facility Genesis Cremation and 21. Signature of Fugeral Service Licensee 23a. Part1. Enter the disease or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. N.W Washington, DC 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sician and burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: Atter this certifica 25. Was case referred to medical examiner2 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X85 2 No 2 Le Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 Natural 1 Tes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Ave. Takoma PK 20912 James 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 1 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 20650 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3:00 P Roy Burton Morgan Jr. June 6, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Ye Apr. 4, 1 **Funeral** Hours Months Days 1 XM 2 □ F 72 Apr. 1936 Tennessee Director 439-52-0501 Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show ofical Examiner must be notified at 1 √Yes 2 No Director Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 amy injury or other traumatic event, the Medical Examples must be recons. 20817 United States 6729 Newbold Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1∐Yes 2XINo Specify: White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Non Profit Social Activist Non Profit 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roy Burton Morgan Sr. Isabel Todd ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Patricia Morgan / Wife</u> 6729 Newbold Dr. Bethesda, MD 20817 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State National Crematory June 12, 08 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service License Man W 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Renal Cell Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Pancreatic Fistula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Coronary Artery Disease attending physician and for use as the burial-tran Due to (or as a consequence of): Hypertension Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Hypothyroidism Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has triector, page 2 s Asthma autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 👿 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

certificate be executed Box 68760, Division of Vital Records, P.O. norizen,

the Maryland

Baltimore, Maryland 21215-0036

Attending Physician: To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral in the f

this

State Registrar

31. Date filed (Month, Day, Year) JUN 1 1 2008

of (

29b. Signature and title



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number D53691

29d. Date signed (Month, Day, Year)

June 7, 2008

			For	State of Marylan					nd Me	ntal Hyg	giene	000	200	51
			For Stata Registrar		Ce	rtifica	e of D	eath			leg. N2 (100	206	
	Physici	an	1. Decedent's Name (First, Middle, La	st) Mbouh					2.	Date of Dea Month June	Day 04,	2008	3. Time of 0	р ^M
ı	/Medic	al	Landon Scott 4a. Facility Name (If not institution, giv			4h City	Town, or L	ocation of	Death	Juile		unty of Death	0.00	
	Examin	er	Holy Cross Hospi			1	ilver					ontgom	ery	
	Funeral		5. Social Security Number 6. S		last birthday,	If Unde	r 1 Year	If Under 24		Date of Birth (Month, Day			lace (State or	Foreign
	Director		None	MM 2□F	0 Yrs.	Months	Days	Hours 1	^{Min.} Jι	ine 04	, 2008	3 Mar	yland	
	p .		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or L	ncation					10d. Inside City			
	shov	5											1 ☑ Yes	2 🔲 No
	the M	ect	Maryland Montgo 10e. Street and Number	mery S	ilver		ng p Code				10g. Citizen of What Country			
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	death ms 2:	Jera	11. Marital Status	12. Was Decedent Ever in U	.S. 13.			panic Origi	in? (Specif	y Yes or No- an, etc.)		Race - Americ Black, White,	can Indian,	
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9	ure!.	d by	3 Widowed 4 Divorced	Year or Dates:								Afric	an-Ame	ricar
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р 5	e filed within al Hygiene. other than '		17. Father's Name (First, Middle, Last)	1	OHC	1	18. Mother	's Name (F	First, Middle,				
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ary	2 should and Men is marke eumatic		19a. Informant's Name/Relationship	Type, Print)	19b. Mail	ing Addres	s (Street an	nd Number	or Rural P	Route Numbe	r, City or To	wn, State, Zip	Code)	
Σ	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "neturel", or items 23s or 28s-f show other treumatic event, the Medical Expiritive fruist its indiffical at		Dominique N. McI	ntosh/ Mother	2924	Bel I	re Ra	od #2	201,	Silver	Spri	ng, MD	20906	
ore	of Hi		20a. Method of Disposition 1 Burial 2 TCremation 3	1 4	Place of Disp cemetery, cre	osition (Na matory or	ime of other place,)	Dat	Ð		ion - City or T		
Baltimore, Maryland 21215-0036	permit. Pages I Department of H Importent: If ite any injury or ot once.		*4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory 6/16/2008 21. Signat#re of Fun at Solid Licensee 22. Name and Address of Facility Simple									twood,	MD	
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			23a. Part1. Enter the disease, or con shock, or Neart failure. List only	plications that coused the deal	th. Do not en	ter the mo	de of dying,	such as c	ardiac or r	espiratory ar	rest,	Maryra	nd 2085 Approximate Interval Betw)
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	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin	owledge, dea ation and/or i	th occurre	d at the time on, in my op	e, date and inion, deat	d place, an h occurrec	d due to the at the time,	cause(s) an date and pl	d manner as ace, and due	stated. to the cause(s))
	To the I within 2.	Med	one) 29b. Signature and title of certifier	and manner stated.		2	9c. License	number			29d. Date s	igned (Month	Day, Year)	
)	7 × 0		Anul	(Q			DO	057	1151		6/	04/200	8	
			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	e, Print)		1						
			D. Walton, M.D.				Silve	er Sp	ring.	MD 20	0904			
	St	ate	31, Date filed (Month, Day, Year)	32 egistrar's Sign	ature	1 1	4							
	Regist	rar	.HIN 112	008 Barrens	K A	18 36 1	<i>P</i>							

		1	State of Maryland / Department of Health a state AMEND#23e,24a/b,25,26,27,29aperMD6-12-08,RW,MD0 Registrar	and Mental	Hygien	e 2 በ በ ន	20652
			Decedent's Name (First, Middle, Last)	2. Date Monti	of Death		3. Time of Death
P	Physicia /Medic		Elizabeth M. Mac Donald	June	2 7,	2008	11:30
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of			C. County of Death	الام
4			Sligo Creek Nursing Home Takoma Pa 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	24 Hrs D Date	of Righ	9 Birtho	lace (State or Foreign
т	. Funeral Director		5. Social Security Number 072-01-3059 6. Sex 1 M 2 T F Age (In yrs. last birthday) Months Days Hours 93 Yrs.	Min. (Mont	28, 191	.5 New	York
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		Director	Md. Prince Georges Mt. Rainier 10e. Street and Number 10f. Zip Code		10a. C	itizen of What Cour	ntry?
	with t	Ö	4105 31st.St. 20712			U.S.A.	
	death	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori	igin? (Specify Yes		14. Race - Americ Black, White,	
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Maryland 21215-0036	should be and Mental marked o	2	Tatlick incommit	lizabeth		11y	Code)
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	1 an Heal am 2 thar	1	John MacDonald (Son) 4105 3181.51. Mt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	-	Location - City or To	own, State
JOH JOH	0 = 0			June10,20	008 _{Riv}	erdale, N	1d.
Baltimore,	permit. Pag Department Important: I any injury o	natorium, 2,Md. 207	P.A.				
	*		29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approximate Interval Between
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	tad rad	Examiner	Sequentially list conditions, if any, leading to minimize the cause. Enter Underlying Cause (Disease or injury				
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6876	cate ba ex physician the burial	dlcal	d				
Box 6	leath certificate k attending physic of for use as the b	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery		
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Division of Vital Records,	or Attendi after death. Director: A in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ation (Street or Town, St	and Number or Ru ate)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Medical Co	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the control of the control of the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and occurred at the control of the basis of examination and occurred at the control of the basis of examination and occurred at the control of the basis of examination and occurred at the control of the basis of examination and occurred at the control of the basis of examination and occurred at the control occurred a	and place, and due	e time, date :	and place, and due	to the cause(s)
	To the within To the comp	Ž	. //			Date signed (Month	
	10			-		0110100	
	V -		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Poris Pablo-Bustos 1140 Varnum St., N.W., Wash:	ington D	.C. 20	017	
	St	ate	2000 a di constante di Cinnotturo	Tigeon De	. 3. 20	321	
	Regist		JUN 1 1 2008				

Physician /Medical Examiner

inding physician and use as the burial-trar

signed by the a d be detached f

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

To the Hospital or Attending Physician:

Director:

within 24 hours a

To the Funeral C

completely filled i

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

"natural",

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of) Due to (of as a consequence of) Due to (or as a consequence of):

23c. If yes, outcome pf pregnancy

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

24a. Was an autopsy autope, performed Yes 2

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No

3 Probably 4 □Unknown

1305

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

White

1 X Yes 2 □ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

29b. Signature and file of certifier

5 Pending investigation 6 ☐ Could not be

determined

Hospital: 28a. Date of Injury (Month, Day

2 ER/Outpatient 3 DOA 28h Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number 54411

29d. Date signed (Month, Day, Year)

ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

M. CALKINS 500 MEMDRIAL AVE, CUMBERLAND MD 21502 M.D. BEVERLY 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature JUN 2 5 2008



			For State Registrar	State o	of Marylan	d / Depa <i>Cer</i>	artment of tificate of	Health <i>Death</i>	and Mer	ntal Hyg R	liene eg. No. 200	8 20655	
Ī	Dhusisi		1. Decedent's Name (First, Middle,	Last)		0 11	1			Date of Deat	Day Year	3. Time of Death	
	Physicia /Medic	al	4a. Facility Name (If not institution,	give street and nu	mher)	1011	4b. City, Town,	or Location	J	une c		09:50 PM	
	Examin	er	The Johns Hopkins	Hospital			Baltimore	Baltimore City					
	Funeral Director		5. Social Security Number 694-09-5563	5. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days 5 2.2	Hours	r 24 Hrs. 8. Min. D	Date of Birth	^{yea} 2007 Vi	irthplace (State or Foreign country) .rginia	
	put w		Usual Residence of Decedent 10a. State 10b. County		10c. Gib	y, Town or Lo	cation					10d. Inside City Limits	
	Maryland -f show ed at	tor	MD Anne A	cundel		rofto						tx∑Yes 2 □ No	
	h the or 28a notifi	Director	10e. Street and Number				10f. Zip-Code			1	0g. Citizen of What Country?		
	death with the Maryland times 23a or 28a-f show must be notified at		1674 Carlyle				2111				USA		
	ould be filed within 72 hours after death with the Mar Mental Hygiene. arked other than "natural", or items 23a or 23a-f s attic event, the Medical Examiner must be notified	by Funeral	11. Marital Status1X Never Married 2 ☐ Marrie3 ☐ Widowed 4 ☐ Divorced	edent Ever in U.S orces? 2 X No ve oates:	in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify:					14. Race - Am Black, Wh Specify: W			
5-0036	'2 hou latural		15. Decedent' (Specify only highest	s Education			dent's Usual Occu		st of working		16b. Kind of Busines	ss/Industry	
Š	rithin 7 ne. nan "n	Completed	Elementary/Secondary (0-12)	College (1		life.	none		ot or morning		none	e	
7 0	Hygier ther th	Co	17. Father's Name (First, Middle, La	ast)				18. Moth	ner's Name (F	irst, Middle,	Maiden Surname)		
land	should be nd Mental marked o matic eve	To Be	Jeremy James Pollock					So	tterr	y Pek			
Mary	iges 1 and 2 should nt of Health and Men if Item 27 is marke or other traumatic		19a. Informant's Name/Relationshi			1	-				r, Cify or Town, State		
e, (o	1 and Health sm 27 ther tr		Jeremy James 20a. Method of Disposition	Polloc		1					Crofton,		
n D	Pages nent of I int: if Ite		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Spi				osition (Name of matory or other place)		6/97* v	2008	Grinnel		
Saltimol	permit. Pages Department of Important: If I any Injury or o		21. Signature of Funeral Service King							FUNER	AL SERVI	CE,P.A.	
מ	9 9 E 8 9		23a. Part 1. Enter the disease, or c	amplications that	caused the death							ng, Md20910	
		8 (1)	shock, or heart failure. List or Immediate Cause (Final	nly one cause on e	each line.			V.				Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)		(or as a consequ	uence of):	hemori	nag	e, mo	ISSIVE		Month	
	Examiner	_	Sacusofially list coodmons	b. He	90+	trans.	Digot					Imonth	
	St. A.G.	Examiner	5 squantially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequent	,	iomyopa	ath.				5 mostly	
	certificate be executed ding physician and use as the burial-transit		that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):	101190pi	arry				J 10011113	
2/90	ite be e iysiciar he bur	edical	•	d					 ,				
ŏ	ertifica ing ph se as t		IF FEMALE:	23c If yes ou	itcome of pregna	ancv					22d Data of d	dollaron.	
ğ	that the death certificate by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live 4 ☐ Preg	birth 2 Feta gnant at time of d	death 3	☐ Ectopic pregnar☐ Other (specify)	ncy			23d. Date of o	Day Year	
	tt the c by the	Phys	9 Unknown	9 🗆 Unkr						no. Did to		to the enume of death?	
	signe ld be	þ	Part II. Other significant condition	is contributing to d	death but not res	suiting in the	underlying cause	given in Par	rt I.	23e. Did to	N. 148	e to the cause of death? Probably 4 🗆 Unknown	
Records,	≥ 0 0	Completed								24a. Was a	sy prior i	autopsy findings available to completion of cause of	
	The page	Соп					<u>-</u>				2 No 1 □ Y		
VITA	Physician: this certificaral director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	* 3 DOA 0	ther:	e of Death (C lursing Home			necify)	
וסו	g Physer this neral d	n: To	27. Manner of Ceath	28a. Date		28b. Time o	of 28c. Inj				ow injury occurred		
UNISION	eath. or: Affe	catio	Natural 5 Pending investigation in Suicide 6 Could not be seen to	ation			M 1	Yes 2			M	Sural Condo Number	
<u> </u>	or Att	Certification:	4 Homicide determin	200. 1 100.	e of injury - At ho ding, etc. (Specify		eet, factory, office		281	City or Town		Rural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		(check only 2 Medical E	xaminer: On the b	basis of examina						cause(s) and manner date and place, and		
	To the H within 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and mai	nner stated.		29c. Licer	nse number		2	29d. Date signed (Mo	onth, Day, Year)	
	5 5 5 5) (+t// At	KT -	MD		RE	5-0	200	-	June 01	2008	
	•		30. Name and address of person v		use of death (Iter	m 23a) (Type	Print)	L	<u> </u>				
	Sta	to	31. Date filed (Month, Day, Year)	Walson 32	egistrar's Signa	ohns k	TOPKINS !	100P1 Ja	HOU NO	ortn WO	ire St, Baitin	nore, MD, 21287	
	Sta Registr			2008	news L	4 60	wie						

State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Anne Prosek 9 2008 4:30a [™] June 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 7701 Woodmont Avenue #606 Bethesda Montgomery 9. Birthplace (State or Foreign Country)
New York If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 4 / 13 / 1948 6. Sex 7. Age (In vrs. last birthday Months Davs Hours 1 □ M 2 🛣 F 60 10c. City, Town or Location 10d. Inside City Limits 10b. County Montgomery Yes 2□No Bethesda 10f. Zip Code 10g. Citizen of What Country? Woodmont Avenue #606 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian. 1 Never Married 2 Married 1 □Yes 2X No Specify. White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Medical Technologist Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Liebst Marie Brogan 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Prosek/Husband 7701 Woodmont Avenue #606 Bethesda, Md20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 6/14/2008 Winfield, Illinois Assumption Cem. 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Lice PHTLTP AD RTNALDI FUNERAL SERVICE, P.A.

Department of Health Important; if item 27 any injury or other trong once. **Physician** /Medical

> the attending p for use as t

> > page 2 s

this

n 24 hours after death.

ne Funeral Director: A pletely filled in by the fu

within 2

20

completely

Pages 1

Examiner Examine law requires that the death certificate be executed sician and burial-trans

23b. V

Physician/Medical

δ

Completed

Be

Certification: To

Medical

23a. Part 1. Enter the disease shock, or heart failure. I	, or complica ist only one	tions that caused the death. Do not encause on each line.	nter the mode of dying, such as cardiac or respiratory arrest,
Immediate Cause (Final disease or condition	_ a.	Glioblastoma	Multiforme
resulting in death)		Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	J b.	Due to (or as a consequence of):	
Cause (Disease or ińjury that initiated events resulting in death) Last	с.	Due to (or as a consequence of):	

deat

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Jane

5. Social Security Number

10e Street and Number 7701

11. Marital Status

10a, State

MD

Director

Funeral

þ

Completed

Be

ပ

341-40-6704 Usual Residence of Decedent

Elementary/Secondary (0-12)

20a. Method of Disposition

Physician

/Medical

Examiner

Funeral

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, it e Modical Expension must be recitied at

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician: The

MALE: √as decedent pregnant i the past 12 months? □Yes 2 □No	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do
Lies ZLINO	9 🗆 Unknown

Member

h	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
h	

Part II. Other significant conditions contributing to death but not resulting in the und

1 🗌 Inpatient

	1		
derlying cause given in Part I.	23e. Did tobacco us	se contribute to the cau	se of death?
	1 □ Yes 2 §	No 3 ☐ Probably	4 ☐ Unknown
	24a. Was an autopsy	24b. Were autopsy fir prior to completion	ndings available on of cause of

9241 Columbia Blvd.Silver Spring, Md20910

aspiration preumonitis

			1 □ Yes	2 X N	0	1 ☐ Yes	2	□No			
	26. Place of Death (Check only one)										
OA	Other: 4 □ Nursing Home 5 ☒ Residence 6 □ Other (Specify)										
28c.	Injury at	28d.	Describe	how inju	ıry	occurred					

25. Was case referred to medical examiner? 1 Tes 2 No 27. Manner of Death 1 X Natural 2 Accident

5 ☐ Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 E

Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 🗌 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D23308 29d. Date signed (Month, Day, Year) June 9,2008

23d Date of delivery

Month

Approximate Interval Between Onset and Death

3 yrs

Day

Year

30. Name and address of person to completed cause of death (Item 23a) (Type, Print)

Hospital:

Victor Priego M.D.

6420 Rockledge Drive #4100 Bethesda, Md 20817

State Registrar

31. Date filed (Month, Day, Year) JUN 10



	1 - State Registrar	State of Mar		artment of l rtificate of		l Mental Hy	giene Reg. No.	2008	2065
	1. Decedent's Name (First, Middle, L	ast)				2. Date of De		Voor	3. Time of Death
Physician /Medical	Harold	P	lotnek			June 6	, 200		8:30 A.M
Examiner	4a. Facility Name (If not institution, ga	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death					4c. County of Death		
	9200 Redwood Ave	enue		Bethe			ı	Montgome	ry
neral ector	5. Social Security Number 6. 589-96-5813	1⊠M 2□ F	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min		th a <i>y, Year)</i> 7 , 19	Cour	
	Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or Lo	cation					0d. Inside City Limits
To Be Completed by Funeral Director			Bethesda						1X Yes 2 □ No
Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citiz Uni țe	zen of What Cour Ed Kingd	ntry? OM
lera	9200 Redwood Av	12. Was Decedent Eve	er in U.S. 13.	20817 Was Decedent of I	Hispanic Origin?	(Specify Yes or No)- I	4. Race - Americ	can Indian.
by Fur	1 □ Never Married 2 🔀 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1		lfYes, specify Cub 1 □Yes 2 🏖 No		(Specify Yes or No erto Rican, etc.)	[Black, White,	
Completed	15. Decedent's E (Specify only highest g	ducation	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of w	orking	16b. Kir	nd of Business/In	
gmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Owner		(a)		Ca	rpet	
Be C		t)			18. Mother's N	ame (First, Middle		•	
10 B					Berth	na Rosenb	erg		
	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street		Rural Route Numb			Code)
1	Avril E. Plotne			Redwood		Bethesda			
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other pla	ce)	Date	20c. Lo	cation - City or To	own, State
	4 Donation 5 DOther (Spec		Garden of						Maryland
once.	21. Signature of Funeral Service Lie		ough Ed	2. Name and Addreward Sage Ward Sage 191 Rockv	ess of Facility el Funer ille Pik	al Direc ce Rockv	tion, ille	Inc. MD 208	52
dical Examiner		a. Coronary Due to (or as a c b. Cardiopat Due to (or as a c c. Hypertens Due to (or as a c	onsequence of): hy onsequence of):	sease				S	udden
Physician/Med		23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		2	23d. Date of delive	ery Day Year
		contributing to death but n	not resulting in the u	nderlying cause giv	ven in Part I.				he cause of death? pably 4 ☐ Unknowr
Completed by							psy ormed?	prior to co death?	psy findings available mpletion of cause of
Be		T			26. Place of D	1 ☐ Yes eath (Check only o	2 X No	1 □ Yes	2 LI NO
TO B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Oth	or:	Home 5⊠ Res		☐Other (Specif	fv)
tion: T	27. Manner of Death 1 ⊠ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Y	28b. Time o	f 28c. Inju Wor		28d. Describe			77
Certification:	3 Suicide 6 Could not I	De Diago of Injuny	- At home, farm, str Specify)		-	28f. Location (City or To	Street and wn, State)	d Number or Rura	al Route Number,
Medical (hysician: To the best of n miner: On the basis of ex and manner stated	camination and/or in						
Me	29b. Signature and title of certifier	10	Λ	29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)
	A	Vant	46	D3384	4		Ju	ne 6, 20	800
	30. Name and address of person who Joseph A. Vassa	,	h (Item 23a) (Type, 4 Wiscons	•	ie #925	Chevy Cl	nase,	MD 2081	.5
State	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	45.1	_				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** \mathbf{A}^{M} NICHOLAS MICHAEL PETITTI SR JUNE 6, 2008 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 609 Denham Road Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1/23/1932 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Pennsylvania 76 Director 204-24-1063 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland ment of Health and Mental Hygiene.
ant: if item 27 ie marked other than "naturei", or items 23a or 28a-f ehow ury or other than the profiled at ury or other traumatic event, the Madical Exeminat main the natifiation at 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shor treumatic event, the Madical Examinar must be notified at Rockville Maryland Montgomery 1 X Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20851 United States 609 Denham Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: **KOREAN** 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☒ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Body & Fender Man Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vito Petitti Sr. Maria Scudieri ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dina M. Stevens - Daughter 609 Denham Rd., Rockville, MD 20851 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 6/10/2008 permit. Page Department of Important: if any injury or once. Brentwood, MD Fort Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Simple of Addison Funeral & Cremation Center 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C. u. e (Final disease or condition resulting in death) Physician MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner ATHEROSCLEROTIC CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **HYPERTENSION** 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably HYPERCHOLESTEROLEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

1 X Yes 2 \(\) No Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 X Natural 5 Pending investigation death. To the Hospital or Attendia within 24 hours after death. To the Funerel Director: A completely filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1000 MD# 32274 JUNE 6, 2008 30. Name and address of person wo completed cause of death (Item 23a) (Type, Print) UNMI KO KIM, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Pritts, Sr. 15 2008 13:10 William Α. June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland Allegany County Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 25, 1919 Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 214-16-2187 88 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygleine.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical France. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☐ No Director LaVale Allegany MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 U.S.A. 716 Braddock Ave. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1943 Black, White, etc. 1 √Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No 1945 Specify Specify. White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Textile Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katie (Gentry) Pritts Arthur M. Pritts ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 716 Braddock Ave., LaVale, MD Jeanetta M. Pritts 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State Jun 19 08 Flintstone, MD - Rocky Gap 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hafer Funeral Service, LaVale, MD 21502 re of Euneral Service Licenses 1302 National Hwy., LaVale, MD 23a. Part. Enter the disease or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIPLE ONE Physician YR. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. Atter this certificate has been signed by the funeral director, page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 2 No 2 ER/Outpatient 3 DOA 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 1 Inpatient Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the letely filled in by the funera Injury (Month, Day Year) 5 ☐ Pending investigation 1 Natural М 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) 2 5 Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robustiano J. Barrera, Jr., Memorial Hospital Bldg., Cumberland MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month ,^{Day}2008 **Physician** 1403 M Reconco Romero June 2 Nicole Leana /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth (Month, Day, Year)
June 2,2008 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Months 1 □ M 2 🛛 F Maryland June none Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Medical Evantina the multibut at 10d Inside City Limits 10c. City, Town or Location 10a State 10h. County 1 □ Yes 2 No Silver Spring MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 20902 10e. Street and Number USA 2720 Arcola Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No 1 √2 Never Married 2 ☐ Married White Saltimore, Maryland 21215-0036 1XIYes 2□No Specify:Honduren ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa Romero Guillermo Reconco ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 2720 Arcola Avenue Silver Spring, Md20902 Guillermo Reconco/Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State permit. Pages Department of Important: If it any injury or o Chesapeake Crem.6/06/2008 Beltsville, Md. 5 ☐ Other (Specify) 4 Donation PHILIP AND RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Severe prematurity Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Premature cervical dilation be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical Hospital or Attending Physician: The law requires that the death certificate attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown þ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? 1 □ Yes 2 No certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 XNatural 5 Pending investigation 1 □Yes 2 □No thin 24 hours after death.

the Funeral Director: A

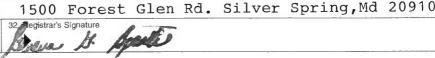
mpletely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and

State Registrar 31. Date filed (Month, Day, Year)

JUN 10 2008

Ann B.Burke MD

30. Nam, and a dress of person willo completed cause of death (Item 23a) (Type, Print)



6-4-2001

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:36 AM Richard John Ripley June 7, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 23696 Tom Price Road Deal Island Somerset If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Days Months Hours Min. 1 M 2 □ F 144-18-5600 83 07/21/1924 Pennsylvania Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural"; or Items 23a or 28a-f show 10d, Inside City Limits 10c, City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Somerset Deal Island 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23696 Tom Price Road 21821 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No IfYes, Give Year or Dates: WWII 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. ð 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chiropractor Chiropractic Pages 1 and 2 should be filed w ment of Health and Mental Hygie tant: If item 27 Is marked other t jury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>George Ripley</u> Ann Richard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy Ripley/Wife 23696 Tom Price Road, Deal Island, MD 21821 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 6/10/2008 4 □ Donation 5 □ Other (Specify) Salisbury Crematory Salisbury, Maryland Signature of Funeral Survival Licensee Hinman Funeral Home 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11673 Somerset Ave., Princess Anne, MD 21853 Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) 1ear **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 DEctopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9☐Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by the performance of the signal of t 2 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy has certificate 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) 1 M Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6-10-08 1604-Market oconick 31. Date filed (Month, Day, Year) gistrar's Signatur State **JUN 12** 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:00 pm June 07 2008 Ronald Irwin Rosenfeld /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Seasons Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1 X M 2 □ F Vrs Director 64 January 31, 1944 District of Columbia 216-40-6585 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show 1 □Yes 2KINo notifled Director Maryland Baltimore Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or ? must be n with 23a 3701 Mohawk Avenue 21207 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, or items 11 Marital Status Examiner Black, White, etc. 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Caucasian "natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 8 None None permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other I any Injury or other traumatic event, <u>th</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myer Rosenfeld Mildred Tebeleff ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beverly E. Polmar - Sister 4302 Dahill Place, Alexandria, Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐Removal from State 06/11/2008 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 a or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bet only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of) Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed Severe Oropharyngeal Dysphagia and burial-trar Due to (or as a consequence of): Physician/Medical the as 1 nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Rectal Prolapse Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Paranoid Schizophrenia autopsy performed? Physician: -2 Be ပ 2 After Certification;

Division or Vital Records, P.O. Box 68760, death. il or Attend after death | Director: / To the Hospital within 24 hours a To the Funeral C completely filled

		1 Yes 2 No 1 Yes 2 No								
5. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 区 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice								
7. Manner of Death 1	(Month, Day Year) Injury M	Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No								
3 Suicide 6 Could not b 4 Homicide determined		fice 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	hysician: To the best of my knowledge, death occurred at t	he time, date and place, and due to the cause(s) and manner as stated.								

715 harcoalise MI

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

> D0057465 June 8, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Niroshi Sharlene Rajapakse, M.D., 25 Main Street, Suite 200, Reisterstown, Maryland 21136

State Registrar

Medical

31. Date filed (Month, Day, Year) 1 1 2008 JUN



State of Maryland / Department of Health and Mental Hygiene 2008 20663 Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1615 Zahid Rasul 6 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Montgomery Olney If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 X M 2 □ F 215-96-8694 Director 57 04/20/51 Pakistan Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Medical Examination in a matter of diffed at 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Montgomery Md. Director Olney 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20832 17509 Gatsby Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, 11 Marital Status Black White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2⊠No ģ If Yes, Give Year or Dates: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur restaurant 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ghulam Rasul Halima Bibi Pages 1 and 2 should I ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau 17509 Gatsby Terrace Olney, Md. 20832 Amjad Rasul/brother Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Laurel, Md. MarylandNational 6/10/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility Universal Mortuary m Mas 411 Kennedy St., N.W. Washington, DC20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Grade Non Hodgkins Lymphoma Low vears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of Examiner it any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Ulnknown 9 Unknown ģ been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Artery Coronary Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 No page 2 certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 D Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D42452 June 9, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Chitra Rajagopal Prince Philip Drive #327 Olney, Md. 31. Date filed (Month, Day, Year) State 1 1 2008 JUN Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 June 13, Physician Martha Elmira RYAN 9:27p.™ /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Williamsport Williamsport Retirement Village WITTIAMOPUL

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | Nov. | 8, 1916 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔯 F 91 220-09-9033 Yrs. Maryland Director Usual Residence of Decedent the Maryland 10d. fnside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylannent of Health and Mental Hyglene.
ant: if item 27 ie marked other than "natural", or itema 23a or 28a-1 ehow ury or other traumetic event, the Medical Examinar must be netified at 10a, State 10b. County 1 Ves 2 No Maryland Washington Hagerstown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1055 Benjamin Place 21742 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ 3 ଔ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) hospital nurses aid 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Hamby Susie F. Bingaman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trai Elmer G. Ryan - son 18831 Preston Road, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) Broadfording Church Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State June 18, 2009 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 tred 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** Circhosis of the liver (uncertain etiology weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner g physicien and as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an Hypertension autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 | fnpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No After this funeral d 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fune 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D47451 June 14, 2008 Daystrea Kuttner Sands of 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) Nursing Home 154 North Artizan Street Cynthia Kuttner Sands No Williamsport Williamsport Maryland 21795 2546 32. Pigistrar's Signature 31. Date filed (Month Pay, Year) 2008

DHMH 17 Rev 1/2001

State Registrar

08-04619

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Anthony Theodore Ruby 2008 20665 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Year 1025 hrs Anthony Theodore Ruby June 15, 2008 Medical Examiner tc. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Abinadon 2938 Carlyle Court If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** reign Country) Maryland Days Hours Min. Director 05/11/1971 213-92-2667 37 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. Count 10c. City, Town or Location Yes 2 X No Harford Abingdon Maryland 28a-f shov notified at once. death with the Maryland Directo 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 2938 Carlyle Court 21009 United States 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after death winten of Health and Mental Hygiene.
ant: If iten 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be: If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 White Yes 1 Yes 2 X No specify: Divorced If Yes, Give Year þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Grocerv Clerk Grocery Store 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur T. Ruby, Jr. Marie Pindell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arthur T. Ruby, Jr./Father 116 Worcester Road, Stevensville, MD 21666 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 XCremation 3 Removal from State 06/19/2008 Edgewater, Maryland Kalas Crematory 4 Donation 5 Other Specify 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Medical Death a. Narcotic (morphine) intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Lister Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed rsician/Medical X UNPENDED AGENTE 27,28a-f, perME, g881 7/2/08 TT the attending physician ed for use as the burial -Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. signed | ć Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' 2 No Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other: Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 1 V Yes After this 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death the Hospital or Attending Certification: Natural Yes 2 X No 5 Pending am1 death. Fnd 6/15/08 Fnd 10:17 Director: the unk 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Funeral Dire 6X Could not be 3 Suicide 2938 Caryle determined Ct. Abingdon, MD found in residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 16, 2008 O.C.M.E. Grasaly 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 31. Date filed (Month, Del.) (2) 200 22. Registrar's Signature 5 Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For PMEND#23a Per PHY. State of Maryland / Department of Health and Mental Hygiene State Registrar 6/13/08 AACO HEALIH DEPT. CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8/2008 **Physician** Pearl Short 3:30pm M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1576 St. Margarets Rd. Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month. Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2xx 89 225-05-6064 5/25/1919 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21409 USA 1576 St. Margarets Rd. Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White ģ 3√√Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir.
Department of Health and Mental Hygien
Important: If item 27 is marked other the
any Injury or other traumatic event. 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ballinger Jones Docia Lawson ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1034 Joyce Mill Rd. Westfield, NC 27030 Andrew Gibbons Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/11/2008 <u> Hillcrest Cemetery</u> Annapolis, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service License Sal Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine requires that the death certificate be executed attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) signed by the a ☐Yes 2 ☐NO P.0. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ₫ 1 | Yes 2 | No 3 | Probably 4 | 1 | 1 | Known bould t Completed Were autopsy findings available prior to completion of cause of 24a. Was an Physician: The law has e 2 autopsy age performed death? te 2 ☐No 1 ☐ Yes 1 □Yes 2 ☑No this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1∐Yes 2⊒No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D57635 June 8, 2008 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis, MD 21401 2001 Medical Parkway Tim Woods, M.D. gistrar's Signatur 31. Date filed (Month, Year)

DHMH 17 Rev 1/2001

State

Registrar

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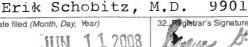
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and .	,		University of Maryland Medical	Center	Ва	Vtixu	ne					
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9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be redified at once.	/ Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give		Nas Decedent of H f Yes, specify Cub			cify Yes or No lican, etc.)	lo- 14. Race - American Indian, Black, White, etc. Specify: Black			
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Baltimore,	Pages 1 au ment of Hea ant; If item ary or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	1\Sou	sition (Name of natory or other place 1s cem.		6/11	/08	Germa	tion - City or To antown	, MD	
Balti	permit. Departr Importa any inji		21. Signature of Funeral Service Licence	22 2	Name and Address 46 N . W	ess of Facili Vashi	_{ity} SNO .ngto	WDEK n St,	Rock	ville,	ME,P.A. MD 20850	
	bhysician and hysician and the burial-transit	Examiner	23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Compared to the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying are should be not enter the mode of dying are should be not enter the mode of dying are should be not enter the mode of dying are should be not enter the mode of dying are should be not enter the mode of dying are should be not enter the mode of dying are should be not entered by a cardiac dying are should be not entered by a cardiac dying are should be not entered by a cardiac dying are should be not entered by a cardiac dying are should be not entered by a cardiac dying are should be not entered by a cardiac dying are should be not entered by									
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ion	nding ath. r: Afte e fune	atio	1 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation	Injury		rk?]Yes 2.□]No					
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my	opinion, de	ath occurre	ed at the time				
	Vith Com	Σ	29b. Signature and title of certifier		29c. Licens	se number				signed (Month,		
	(lugthe mo	00-1 (7	Point No	220	75	-40	06-	-03-2	2008	
			30. Name and address of person who completed cause of death (Item 22 September St. Balt	∠sa) (Type, I	LID	4	2120	1				
	Sta	ite	31. Date filed (Month, Day, Year) 32 Registrar's Signat	ure	- AF A		,	•				
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State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Dr, Rockville, MD 20850

29c. License number

2006660000

29d. Date signed (Month, Day, Year) 6-1-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistrarAMEND#23a(b)perMD 6-11-08,BW,MbCo Certificate of Death Reg. No. 2008 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Loraine Covington Smith 3:30 A^{M} 2008 June 4, 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Chevy Chase 5204 Dorset Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 97 559-26-5438 1 □ M 2X F Texas 01/04/1911 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No Maryland | Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20815 5204 Dorset Avenue United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Frances Raiford Robert Ewell Covington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5204 Dorset Avenue Chevy Chase, MD 20815

17. Father's Name (First, Middle, Last)

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~- " any injury or other traumatic events."

Physician

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Hospital or Attending

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attending physician the SB

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

William Arthur Smith / Husband 20a. Method of Disposition

1 N Burial 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemet 6/12/08

20c. Location - City or Town, State Silver Spring, MD

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral S. Nice Licensee

22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016

Immediate Cause (Final disease or condition resulting in death)

23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Pneumonia Due to (or as a consequence of):

Approximate Interval Between Onset and Death Days

Days

Sequentially list conditions, if any, leading to immediate cause Cluses or injury that initiated events resulting in death) Last

lapiration Due to (or as a consequence of)

Due to (or as a consequence of)

IF FEMALE:

Physician/Medical Examiner

Completed by

Be

Certification: To

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 XNo

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death 9 Unknown

28a. Date of Injury (Month, Day Year)

and manner stated

3 ☐Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Diabetes Mellitus

Hypertension Hypertensive Heart Disease 24a. Was an autopsy performed 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

25. Was case referred to medical examiner?

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death Check onl one Other: 4 ☐ Nursing Home 5 🏋 Residence 6 ☐ Other (Specify)

1 ☐ Yes 2 2 No 27. Manner of Death 1 🖾 Natural

2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be 28b. Time of 28c. Injury at Work? М

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 4686

29d. Date signed (Month, Day, Year) June 4, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jerry Allison Snow MD 4900 Massachusetts Ave. NW #300 Washington, DC 20016

State Registrar

31. Date filed (Month, Day, Year) 1 1 2008 JUN

32 Registrar's Signature

			For State		State	of Mar	yland / l	-	ırtment <i>tificate</i>			nd M	ental Hy	giene	20	008	21	1670
		Decedent's Name (First, Middle, Last)													2. Date of Death			e of Death
	Physicia /Medic		Steph	en H	. Selta	zer										2008	8:2	5 P. M
	Examin		4a. Facility Name (If not institu	ition, giv	e street and no	umber)			4b. City, Town, or Location of Death				4c. County of Death			th		
			9424 Rosehil							Bethesda				Montgomery				
F.	Funeral		5. Social Security Number		Sex 7. Age (In yrs. last birthday) 1X M 2□ F 66 Yrs.				If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Sept.	th ay Year,) 194	9. Birt	hplace (Sta untry) ash.	te or Foreign
Šu.	Director		219-36-9823 Usual Residence of Decedent				66						Bept.	22,		r w	asii.	D. C.
	/land		10a. State 10b. Cou	nty		1	0c. City, Tow	vn or Loc	cation									e City Limits
	a-f sh lified	cto	Maryland Mon	tgon	nery		Bet	thes	da						1 Mayes 2 No			
	or 28	Director	10e. Street and Number						10f. Zip 0							f What Co	-	
	ath wi	la l	9424 Rosehill	Dr						817						S. A.		
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2☐ I 3 ☐ Widowed 4 ☒ Divor		Armed F	orces? 2 No live	2 PNo ive 1 □ Yes 2 NNo Specify:				city Yes or No Rican, etc.)	0-		ack, Whit	erican Indiar e, etc. White			
5	72 hou "natura dical E	Completed	15. Decedent's Education (Specify only highest grade completed)				168	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						16b. Kind of Business/Industry				
7	within iene. than '	ldmo	Elementary/Secondary (0-1 12 Years	2)	College	(1-4or 5+)		Owr		е гешгеа)				Pr	int	ing	Firm	
מ	e filed al Hygi other vent, t	Be C	17. Father's Name (First, Mid		t)					1			(First, Middle	, Maide	n Surna	ame)		
yla	Menta Menta arked atic ev	To E	Morris Seltzer															
Mar	and 2 sh ealth and 27 Is m er traum		19a. Informant's Name/Relat Jerri S. Fal			er	19	b. Mailin 3494	g Address (Const	Street and cella	nd Numbe ation	Dri Dri	ve, Da	vids	or Tow.	rille	21035	yland
ב ב	Jes 1 and He		20a. Method of Disposition 1 XBurial 2 ☐ Cremati	on 3X	☑Removal fror	n State		ery, cren	natory or otl	her place,			ate			-	Town, State	
Dallinior	tment tant:		4 □ Donation 5 □ Othe	r (Speci	ify)		King		id Men									irginia
ā	Depar Impor any Ir		21. Signature of Funeral Sen		Stock	ttem	yer	$\rightarrow 10$	091 Re	ockv:	ille	Pike	l Dire	ViL.	on, le,	Inc. Mary	1and	20852
			23a. Part1. Enter the disease shock, or heart failure.	e, or con List only	nplications that y one cause on	caused the	death. Do	not ente	er the mode	of dying	, such as	cardiac c	r respiratory	arrest,			Approx Interval Onset a	mate Between and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)				wany		there	scl	eno	20						
	/Medical Examiner		resulting in death)		Due to	o (or as a c	consequence	e of):										
		<u>.</u>	Sequentially list conditions,		b. Dus t	(or as a c	consequence	د الان								- 0		
	uted d ansit	Examiner	ramy, leading to influediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of the c															
) כ	an an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):															
00/0	ate be hysicii he bu	dical		•	d													
Ď	ing ph e as t	Med	IF FEMALE:		00- 15												-	
J. DOX	e death o	Physician/Me	250. Was decedent pregnant 1 Live high 0 Cotol dooth 2 Cotopic prognance								Date of delivery Month Day Year							
ŗ	that the ed by detac										ontribute t	ribute to the cause of death?						
coras,	quires n sign ıld be	d b	<u>Colitis</u>										1 🗆	Yes 2	2□ No	3 □ P	robably 4	1 Thinknown
Leco	ne law rec has beer ge 2 shou	Completed by											24a. Wa: auto per	opsy formed?		prior to death?	completion	ngs available of cause of
N II a	ificate or, pa		25. Was case referred to me	dical							26. Place	of Death	1□ Yes (Check only		lo	1 ∐ Ye:	s 2□No	
>	ysicia is ceri	To Be	examiner? 1 ☐ Yes 2 ☐ NO		Hospital: 1] Inpatient	2 🗆 ER/C	Dutpatien	nt 3□ DO/	Othor			me 5 Nas	^	6 🗆 0	Other (Spe	ecify)	
0	ng Ph ter thi		27. Manner of Death 1 Natural 5 ☐ Pe	ndina		e of Injury		. Time of	f 28	Bc. Injury Work?	at ?		28d. Describe	how inj	ury occ	curred		
<u> </u>	tendir sath. or: Al	atic	2 ☐ Accident inv	estigation					М		es 2□			(0)				
DIVISION O	after de after de Direct	Certification:		termine	1 200. Fla	ce of injury Iding, etc.	/ - At home, t (Specify)	tarm, str	eet, ractory,	, опісе			28f. Location City or To			mber or H	rurai Houte	Number,
	To the Hospital or Attending Physician: The law requires that the de.th certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the arending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit	Medical C			hysician: To t aminer: On the and ma	he best of basis of e anner state	my knowlede examination and	ge, deati and/or in	h occurred a vestigation,	at the time in my op	e, date ar inion, dea	nd place, ath occur	and due to the	e cause(e, date a	(s) and ind plac	manner a ce, and du	is stated. le to the cal	use(s)
•	To th withir To th	Me	29b. Signature and title of ce	difier	V		М)	29c.	License OD	number 570	32	—	29d. D	ate sig	ned (Mon	th, Day, Ye	ar)
-	5		30. Name and address of pe	son who	completed ca	use of dea	ath (Item 23a)	Type,	Print)	200/	Cede	.0	Dr, Sv	le 2	200	be	thesde	MAD
	Sta Registr		31. Date filed (Month, Day,	ear)	08	Registrar	's Signature	A STATE OF THE PARTY OF THE PAR	A.S.	-000	مر در د	, -	,-01	10 -			Ju	JI T
	J		00		A	1917	9	P										

State of Maryland / Department of Health and Mental Hygiene 2008

		•	State Registrar				Cert	tificate	of D	eath			Reg. No.	2000	1 21	1011	
			1. Decedent's Name (First, Middle, Last)									2. Date of De Month		Day Year		of Death	
緩		Physician Siegfried J. Schwantes							June				1, 2008 3:4			A M	
3	Examin	Janes .	4a. Facility Name (If not institution	on, give street and	number)			4b. City, Town, or Location of Death						4c. County of Death			
			10613 Meadowhill Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda						Silver Spring Montgomery World Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or Fo							=	
1	Funeral Director		5. Social Security Number 215–40–5393	1 M 2 F 92 Yrs. Months Days Hours Min. JW9							8. Date of Birl July 2	ate of Birth Manth, Day, Year 915 11 Y 24, 1915 9. Birthplace (State of Country) Brazil			or Foreign		
	pun ,		Usual Residence of Decedent 10a. State 10b. County	v		10c. City, Town	or Loca	ation							10d. Inside	City Limits	
	e Maryla Ba-f shor tified at	ctor	Maryland Montg	-		Silver		ing								s 2□No	
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 10613 Meadowhi	.11 Road				10f. Zip Co 20901					Bra	zen of What Cou ${ t zil}$	ntry?		
	deal sms	ner	11. Marital Status	Armed	ecedent Forces?	Ever in U.S.	13. W	as Deceden Yes, specify	t of His Cubar	spanic Ori	gin? (Spec	cify Yes or No	- 1	 Race - Amer Black, White 			
920	urs after al', or its Examine	þ	1 □ Never Married 2 Ma 3 □ Widowed 4 □ Divorce	rried 1 🗆 Ye	s 2 1	1 ☐ Yes 2 H No Specify:							Specify: White				
2-0	72 ho natur fical	eted	15. Decede	ent's Education lest grade complete	ed)	16a.	Decede	ent's Usual C ind of work of O NOT use r	occupa done di	tion uring mos	t of workin	g	16b. Kin	nd of Business/I	ndustry		
2121	d within giene.	Completed	Elementary/Secondary (0-12)		e (1-4or 5	i+)		o NOT use r fessor					Teaching				
Baltimore, Maryland 21215-0036	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle Arnaldo Schwan					(First, Middle, orezna	, Maiden S	Surname)							
Mary	ind 2 shou alth and N 27 Is mai		19a. Informant's Name/Relation Maria Dias Sch		Wife									or Town, State, Zip Code) ing, MD 20901			
more,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (om State	20b. Place of cemeter Fort L	v. crem	atory or other	er place	tory		ate '08		twood,			
Balti			21. Signature of Fure al Service Licensee Simple Tribute Tribute Pike, Rockville, MD 20852											Center 852	:		
			23a. Part1. Enter the disease of shock, or heart failure. List			the death. Dorne. L Vascul				g, such as	cardiac or	respiratory a	rrest,		Approxim Interval B Onset and	etween	
	Physician /Medical Examiner		disease or condition resulting in death)	a		a consequence of		ACCIGO									
0	sit. 9d	iner	Sequentially list conditions, if any, leading to immediate cause. Enter University in Cause (Disease or injury that initiated events c.														
C8760, U	certificate be executed ding physician and use as the burial-transit	I Examiner	that initiated events resulting in death) Last														
876	ate b thysic	Medical		d													
. Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Med										23d. Date of delivery Month Day Year			Year		
ds, P.	uires that t signed by id be detac	d by Ph	Part II. Other significant condi	tions contributing t	o death b	ut not resulting in	the un	derlying caus	se give	n in Part I				se contribute to	_	_	
Division or Vital Records, P.O	2 38	Completed										24a. Was auto perfe	an psy ormed? 2 X No	24b. Were au prior to o death?	completion of	s available cause of	
ā	ician: Th certificate ector, pag	ပ္	25. Was case referred to medic	eal	-					26 Place	of Death	1 Yes (Check only		1 ☐ Yes	2□ No		
5	/sicia s cert direct	o Be	examiner? 1 ☐ Yes 2X No	Hoopitali	☐ Inpatie	ent 2∐ER/Ou	tpatient	3∏ DOA	Othe	and a				6 □Other (Spec	cifv)		
on or	ding Phys n. After this funeral di	ion: To	27. Manner of Death 1 Natural 5 ☐ Pend	28a. D	ate of Inju Month, Da	iry 28b. 1	ime of		. Injury Work		2	8d. Describe			,,		
Division	fter o	Certification:	3 Suicide 6 Could	d not be 28e. Pl	ace of inj uilding, et	ury - At home, fa c. (Specify)	rm, stre					8f. Location (City or To	Street and wn, State	d Number or Ru)	ral Route N	umber,	
	To the Hospital of within 24 hours at To the Funeral Completely filled it	Medical C		ying Physician: To al Examiner: On the and n		f examination an										e(s)	
	1	Me	29b. Signature and title of certif		zm	me 1	VII			number				e signed (Monta	ı, Day, Year)	
	5 (5)		30. Name and address of person Merlyn Vemu	on who completed o	ause of c	leath (Ithm 23a)			Si	lver	Spri	ng, MD					
	Sta Registi		31. Date filed (Month, Day, Yea JUN 11	ar) 3	Registi	rar's Signature					1	<u> </u>					
			2011 11		THE LAN) N. 1		Contract of the Contract of th									

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death John H. Skipper Jr. Month Year Physician JUNE <u> 2008</u> 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKIUS BAYVIEW MEDICALIENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 20, 1956 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 10XM 2□ F Months Days Hours Min. 216-76-1606 51 Pennsylvania **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f shov r items 23a or 28a-f shorther at Director PAYork New Freedom 10e. Street and Number 10f. Zip Code 1047 Windy Hill Road 17349 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Nam Be Mental Pages 1 and 2 should be is marked John H. Skipper, Sr. Betty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ruof Health item 27 i Crystal A. Skipper, Wife 1047 Windy Hill Rd 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition permit. Pages
Department of
Important: If its
any injury or o June 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 emetery 22. Name and Address of Facility J. 21. Signature of Funeral Service Licensee Meil El. Me 24 Second St., Ne 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HYDROCEPHALUS /Medical Due to (or as a consequence of): Examiner INTRACEREBRAL Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed COCAINE ABUSE and Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No

g Unknown

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATHIOUDIAKIS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

HYPERTENSION

1 Impatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.

28b. Time of

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Bepartment of Health and Mental Hygiene

		1 1 103 2 2	1
10g. (Citizen of What Co	untry?	
	U.S.A.		
10g. Citizen of What Country? U.S.A. ecify Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Trucking a (First, Middle, Maiden Surname) Calp al Route Number, City or Town, State, Zip Code) . New Freedom, PA 17349 Date 20c. Location - City or Town, State Beckleysville, MD J. Hartenstein Mortuary, Inc. Ew Freedom, PA 17349 Or respiratory arrest, Approximate Interval Between Onset and Death 48 Hours DAYS DAYS 23d. Date of delivery Month Day Year 24a. Was an autopsy performed 1 Yes 2 No 3 Probably Probably 24a. Was an autopsy performed 1 Yes 2 No 3 Probably 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 24d. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 24d. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 24d. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 24d. Describe how injury occurred 24d. Describe how injury occurred 28d. Describe how injury occurred			
	Specify: W	What Country? A. e - American Indian, ick, White, etc. w White usiness/Industry ing State, Zip Code) Om, PA 1734! City or Town, State sville, MD Mortuary, Inc. A 17349 Approximate Interval Between Onset and Death 48 Hooks DAYS te of delivery with Day Year ribute to the cause of death? 3 Probably 4 Inknow Were autopsy findings available prior to completion of cause of death? 1 Pyes 2 Hoo Der (Specify) Ted And due to the cause(s) d (Month, Day, Year) 16, 2008	
	U.S.A. (res or No- In, etc.) 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Trucking It Middle, Maiden Surname) Ip Ite Number, City or Town, State, Zip Code) New Freedom, PA 17349 20c. Location - City or Town, State Beckleysville, MD Hartenstein Mortuary, Inc. Freedom, PA 17349 piratory arrest, Approximate Interval Between Onset and Death 48 Hours DAYS 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy in Yes 2 No 3 Probably 4 Unknown 25eck only one) 5 Residence 6 Other (Specify) Describe how injury occurred 25d. Date signed (Month, Day, Year) JUNE 16, 2008		
Т	rucking		
(First, Middle, Maide	en Surname)		
Calp			
			49
20c.	Location - City or	Town, State	
Bec	kleysvil	le, MD	
	Trucking It, Middle, Maiden Surname) Ip Ite Number, City or Town, State, Zip Code) New Freedom, PA 17349 O, 20c. Location - City or Town, State Beckleysville, MiD Hartenstein Mortuary, Inc. Freedom, PA 17349 Piratory arrest, Approximate Interval Between Onset and Death 48 Kooks DAYS 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? Proper of Promad? Proper of Completion of cause of death? Operior of Completion of Course of death? Operior of Course of Describe how injury occurred Oper of Course		
	T.	Approximate	
		Onset and Deat	n
	-	TR HOUR	7.2
10g. Citizen of What Country? U.S.A.			
	= 2		
		DAYS	
		-	
	MOTILIT	Day Teal	
One Did tohana	a usa santributa ta	the series of death	
		,	
1 ∐ Yes	2 No 3 Pr	obably 44 Unkr	iown
24a. Was an	24b. Were au	topsy findings avail	lable
performed?	death?		
		2 2	
	6 ∏Other (Spe	cify)	
28f. Location (Street	and Number or Ru	ıral Route Number,	
City or Town, Sta	ate)		
and due to the cause	e(s) and manner as	stated.	
004 [Date signed (Monta	n, Day, Year)	
29d. L			
	14 16	2000	

20672

3. Time of Death

10:28 AM

10d. Inside City Limits

I DV-- OMN-

State Registrar

within 24 hours after death.

To the Funeral Director: A completely filled in by the form

Division of Vital Records, P.O.

31. Date filed (Month, Day, Year) JUN 2 5 2008

5 Pending

investigation 6 Could not be determined

g ☐ Unknown

ALCO HOLIS M

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death 1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

NESTORAS

3 Suicide

<u>≨</u>

Be Completed

Medical Certification: To

U.N.

5 ☐ Other (specify)

28c.

26. Place of Deat

Other: 4 \(\text{Nursing He}

1 □Yes 2 □ No

29c. License number RES-000

4940 EASTERN

State of Maryland / Department of Health and Mental Hygien 2 1 2 20673 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2008 Year **Physician** Teddy 9 10:30A M Henry Stieringer June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett County Mem'l Hospital Oakland Garrett If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 WV 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2/6/ 1931 Funeral 6. Sex 12 M 2 ☐ F Days Hours Min Director 232-46-8492 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r then "natural", or Items 23a or 28a-f show the Medical Examinational be notified at 1 ¥Yes 2 ☐ No Be Completed by Funeral Director Preston Aurora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rural Route 1 Box 212 26705 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 28 Yes 2 DNo 179s, Give Year or Dates: 1952-53 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed withIn Health and Mental Hygiene. em 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Coal Miner 11 Coa1 of Health and Mental Hyges: If Item 27 Is marked other or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Lucinda Stieringer ပ unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Stieringer/wife Rt.1 Box 212 Aurora, WV 26705 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. 4 Donation 5 Dother (Specify) 6/12/ 08 Aurora Cemetery Aurora, WV 21. Signature of Funeral Service Licensee Hinkie Tuneral Home P.O. Box 186 Davis, WV 26260 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician pneumonia weeks /Medical Due to (or as a consequence of): **Examiner** congestive heart failure weeks Sequentially list conditions, if any, leading to immediate cause for the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit emphysema years Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 Probably 402 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 ☑ No or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral dir 1 ☐ Yes 2 🔀 No 1x Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 / Homicide To the Hospital within 24 hours of To the Funeral 29a. Certifier 1\(\text{LS}\) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number D0023979 06/13/2008 30. If me and add is of person who completed cause of death (Item 23a) (Type, Print) кobert A. Goralski, M.D. 311 N Fourth Street Oakland, MD 21550 31. Date filed (Month, 2 5 2008 32. Registrar's Signature State Registrar

Synthia Varyhin **UNK UNK**

28a-f show

death with the Maryland

21215-0036

MD

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 20674 Certificate of Death 1- For State Reg. No 3. Time of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 27, 2008 2034 hrs VAUGHN SYNTHIA Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Beltsville 13212 Greenmount Avenue If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Country) ALABAMA Funeral Min. Months Days Hours 09/13/1932 417-50-3311 Director 2 X F 75 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h Count 10a, State 1 XYes 2 No PRINCE GEORGES MD BELTSVILLE items 23a or 28a-f showns to be notified at once. Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20705 USA 13212 GREENMOUNT AVE. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. must be 1 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Specify: BLACK 2 X No Yes 1 Yes 2 X No specify: Yes, Give Yaar permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", o injury or other traumatic event, the Medic I Examiner in injury or other traumatic event, the Medic I Examiner in injury or other traumatic event, the Medic I Examiner in injury or other traumatic event, the Medic II Examiner in injury or other traumatic event, the Medic II Examiner in injury or other traumatic event, the Medic II Examiner in injury or other traumatic event, the Medic II Examiner in injury or other traumatic events. 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 3 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) PRIVATE TEACHER 4YRS 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BOYKINS EŁMA Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 857 WILLOW BROOK DR., MONROE, OHIO HART/ NIECE MARSHA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 06/13/2008 SAMSON, ALABAMA SAMSON CITY CEMETERY Donation 5 Other Specify 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL FOME 21. Signature of Funeral Se ice Lic nsee 716 KENNEDY ST. NW, WASHINGTON, DC complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 2 a. Part I. Enter the list 50, Between Onset and **Physician** failure. List only the cause on each line Death (Medical a Atherosclerotic cardiovascular disease complicating Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Hyperthermia Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED AMENDED 27,28a-f,perME,g881, 7/1/08 TT ending physician use as the burial -23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 3 Ectopic pregnancy 23h Was decedent pregnant in the Live birth Fetal death past 12 months? 5 Other (Specify) Pregnant at time of death signed by the atte 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Vunknown ş Completed 24b. Were autopsy findings available 24a. Was an s been si should b prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No r this certificate ha al director, page 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other; Nursing Home 5 Residence 6 ✔ Other: Scene examiner? Hospital: 1 Inpatient 2 DOA ER/Outpatient 3 1 Yes 2 No 28d. Describe how injury occurred subject exposed to hot ဥ 28c. Injury at Work? 28a, Date of Injury (Month, Day, Yaar 28b. Time of Injury After 27. Manner of Death Yes 2 X No 1 ... Natural 5 Pending Investigation Fnd 5/27/08 lunk environment the 28f. Location (Street and Number or Rural Route Number City 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)
1312 Greenmount Ave. Beltsville, 3 Suicide Could not be determined (Specify) residence Δ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: cal

The law requires that the death certificate be

Physician: of Vital

Box 68760.

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Records.

Division

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b Signature and title of certifier

May 28, 2008 O.C.M.E.

30. Name and address of person who complete caus o death (Item 23a Assistant Medical Examiner Zabiullah Ali, M.D.

111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year) 2008



ORIGINAL

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29d. Date signed (Month, Day, Year)

		State of Maryland / Department		-	ne.	20675					
		1 - State Certificate	of Death	Reg	2008	20675					
Physicia	n	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death					
/Medic	al	Annie Catherine Willoughby 4a. Facility Name (If not institution, give street and number) 4b. City, T	own, or Location of Death	June	16, 2008 10:30 A M						
Examine	er 		iamsport	-	Washington						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Vear If Under 24 Hrs	8. Date of Birth	0.00	hplace (State or Foreign					
Director		436-05-7687 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Days Flours IVIII.	Month, Day, Y Pebruary 26	,1917 LA						
land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits					
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D36	<u>۾</u>	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 Married 1 Yes 2 No If Yes Control Year or Dates:	No Specify:		Specify:	ite					
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Baltimore, permit. Peges 1 ar Department of Hea Important: If Item any injury or other page.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	ner place)		c. Location - City or						
Itim it. Pe it. Pe rtant: njury		4 Donation 5 Other (Specify) Smithsburg Crem 21. Signature of Funeral Service Licensee // 22. Name and									
Baltimore permit. Peges Department of the Important: if the any injury or of once.			Address of Facility 14		ain Stree						
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/Medical Examiner		resulting in death) a. Due to (or as a consequence of):				5 DAYS					
ŧ		Sequentially list conditions b. DEHYDRATION									
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Division of Vital Records, or Attending Physician: The law requires ta after death. Director: After this certificate has been signed in by the funeral director, page 2 should be control.	Completed by			24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of					
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To th To th comp	E I	29b. Signature and title of certifier 29c.	License number	29d	. Date signed (Mont	h, Day, Year)					
•		2 Tollowe M2	33700	丁	WE 18	2008					
4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	741			21795					
State	9	TED E. Howe, MD 154 N. ARTIZAN S 31. Date filed (Month, Day, Year) JUN 2 5 2008	>1. Will()	TVVV S FOR	(, 14 (8)	21173					
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	Physici	an	1. Decedent's Name (First, Middle, Last	t)				2. Date of Death	1	3. Time of Death			
	/Medic	cal	Patricia Winslow	street and number		Ab Tity Journ	or Location of Death	June	8 700	8 4:22P.M			
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	ns 23	Funeral	11. Maritat Status	12. Was Decedent Ev	er in U.S. 1	3. Was Decedent of I		ecify Yes or No-	14. Race - Am				
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, Ira Madical Examinar must be notified at	by Fur	1 ☐ Never Married 2 ← Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? ★☑Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 🙀 No		Rican, etc.)	Black, Whi	te, etc.			
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/Jan	uld be Mental rrked c	To Be	Noble Richard Thor	mpson Jr.	h Morgan	,							
Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any njury or other traumatic en 2006.		19a. Informant's Name/Relationship (T) James Russ Winslo			N Route Number, City or Town, State, Zip Code) Catonsville, MD 21228							
Baltimore,	of Hea of Hea if Item or othe		20a. Method of Disposition	Removal from State	20b. Place of Dis	position (Name of rematory or other pla	ce)	Date 2	Oc. Location - City or	Town, State			
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<u>></u>	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 □ Inpatient	2 R/Outpat	ent 3□ DOA Ott	205		nce 6 Other (Spe	ecity)			
	fte fine		27. Manner of Death 1 □ Naturat 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day)	28b. Time (ear) Injun	Wo	y at rk? Yes 2 □ No	28d. Describe how	w injury occurred				
DIVISION	- 0	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	- At home, farm, (Specify)	street, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,			
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	To the within 2 To the complex	Me	29b. Signature and title of certifier	7		29c. Licens	se number	29	d. Date signed (Mon	th, Day, Year)			
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1	424		30. Name and address of person who co	o eted cause of dea	th (Item 23a) (Typ	e, Print)	1 Patra	Ann	12 1.Lm	man I I			
	Sta	te	31. Date filed (Month, Day, Year)	32. degistrar	s Signature	11/4/ 700	CRIONI	verve	13a//1100	re / wrylant			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician BERNARD ROY WHITING JUNE 3 2008 8:15 AM /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Casey House MONTGOMERY Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F Director 219-74-0700 47 21,1961 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If Item 27 Is merked other then "neturel", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at MD Montgomery Gaithersburg 1 TYes 201No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 947 Clopper Road, #A-4 20878 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2 XNo f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ò Specify. Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed 12th Handyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James R. Whiting Rosetta F. Bryant ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 19a. Informant's Name/Relationship (Type. Print) Rosetta F. Whiting (Mother) 947 Clopper Rd, #A-4, Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burialy 2 □ Cremation 3 □ Removal from State Ash Memorial Cem 6/7/08 Sandy Spring, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign Ture of Funeral Service Lious SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cryptococcal Meningitis /Medical Due to (or as a consequence of): **Examiner** Acquired Immunodeficiency Syndrome if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 XNo or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 (XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. one) 29b. Signature and ville of certifier 29c. License number 29d. Date signed (Month, Day, Year) D064615 6/3/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, M.D. 6001 Muncaster Mill Rd, Rockville, MD 20850

State Registrar

Medical

31. Date filed (Month, Day, Year) JUN 1 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20678 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0135 AM Murray Lee Williams, Jr. 200Y /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBUR WICONIC REGIONAL Mediese Date of Birth (Month, Day, Year) If Under 1 Year Social Security Number Age (In yrs. last b. If Under 24 Hrg Birthplace (State or Foreign Country) Funeral Days Months Hours 1 M 2 □ F 74 216-30-7448 Director 07-19-1933 South Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, Its Medical Exerting must be notified at Director 1 ☐ Yes 2 No Somerset Princess Anne 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12881 Recycle Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1953–55 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 1 ☐ Never Married 2 ☐ Married "natural", or Baltimore, Maryland 21**2**15-0036 1 □Yes 2 No Specify q Specify: 3 Nidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none Owner Tavern 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any Injury or other traumatic ev Murray Lee Williams, Sr. ပ Margaret Dixon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Dale Williams/son 6605 O'Donnell Street, Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 6/10/2008 Salisbury, Maryland Salisbury Crematory Signature of Funeral/Service 22. Name and Address of Facility. Hinman funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SNONARY an disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical the SS 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š sign I be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifie

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Rastrar's Signature

08-04596 Stanley William \	Nar			Black Indel						ible.	200		067
		i- For State Registrar	-	Certific						j. No.	200	18 2	Ub /
Physicia Medical Examir	W/	Decedent's Name (First, Middle	,						Date of Death Month	Day	Year	3. Time of D 1550 hr	
C'		Stan1e 4a. Facility Name (if not institution			rcha	4b. City, Town, or	Location of		une 14, 20		ounty of Deat	<u> </u>	
3		328 West Edmonston		•		Rockville				Mor	ntgomery		ļ
Funeral			. Sex	7. Age (In yrs. last bir	thday)	If Under 1 Year		24Hrs. 8	. Date of Birth	(MM/DD	/YYYY) 9. Bi Fore	rthplace (Stata	or
Director		215-72-7982	1XM 2F	44	Yrs		Hours	MIII.	07/20/	1963		and a land	A
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locat	ion						10d. Inside	City Limits
*		MD. Montg	nmerv	Rock	v1114	a						1 X Yes	2 No
s S Anit the Maryland 123a or 28a-f show a cotified at once.	Funeral Director	10e. Street and Number	Jilet y	ROCK	<u> </u>	10f. Zip Code			10	g. Citizen	of What Co	untry?	
the M		328 West Edmons	ton Drive	e		20852				Uni	ited S	tates	
h with	eral	11. Marital Status	12. Was Dec	edent Ever in U.S.		as Decedent of His				14.	. Race - Ame White, etc.	rican Indian, B	lack,
or ite	핊	1 X Never Married 2 Mar	1 Yes							Specify: White			
urs afte	<u>\$</u>	3 Widowed 4 Divo	or Dates:		Deceder	Yes 2 X No		nd of work	done		of Business	hite /Industry	
72 hou	etec	Elementary/Secondary (0-12)	College (1		during most of working life. DO NOT use retired)								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	12			Te	echniciar					ompute	rs	
15-C filed v 1 Hygi sd oth		17. Father's Name (First, Middle, I		1 11			18.Mother's	•	rst, Middle, M			1	
212. Jid be Menta marke	o Be	Theodo		chall	9b. Mailin	g Address (Stree	et and Numb		Eileen al Route Num				
MD d 2 short th and n 27 is tumatic	_	Eileen P. Warch	r 1	100 5	S.W. Shor	eline	e Dr.	, #122	,Pal	m City	, FL.3	4990	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after dinent of Health and Mental Hygiene. Instit. If item 27 is marked other than "natural", or or other traumatic event, the Medical Examiner more.		20a. Method of Disposition 1 Burial 2 X Cremation	20b. Place	of Dispos	sition (Name of cer her place)			ate			or Town, State		
Pages nent of nnt: I	4 Donation 5 Other Spe	UIII Stata	poli	tan Crema	atory	6/16	/2008	Ale	xandri	a, VA.			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	-	21. Signature of Funeral Service L		00	22. 1	Name and Address	of Facility	DeVo	1 Fune	ral :	Home		
	_	23a Part I Enter the disease or o	omplications that ca	aused the death. Do r	10	East Dee	er Par	rdiac or re	., Gai	ther	sburg,		0877 ate Interval
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s failure. List only one cause on each line. Immediate Cause (Final disease a, Head injury associated with cirrhosis of liver									, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Between	Onset and eath
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Box 68760, e death certificate bethe attending physical for use as the burden but the burden as the burden	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		outcome of pregnancy wirth	_	etal death 3	Ectopic	pregnanc	4		Date of delive onth	Day	Year
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tal Records, P.O. Box 68760, cian: The law requires that the death certificate be excertificate has been signed by the attending physician ector, page 2 should be detached for use as the burial-	Phy	Part II. Other significant condition	9 Unknic		ng in the	underlying cause g	given in Par	t i.	23e. Did to	bacco us	e contribute	to the cause of	death?
P.O.	ρ	·	•						1 Yes	2 🗸 🛚	No 3 Pr	obably 4	Unknown
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of Vital Records, ng Physician: The law requir After this certificate has been s neral director, page 2 should	8	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 ER/	Outpatien	t 3 DOA	Other _	Nursing I	lome 5	Residenc	e 6 🗸 Otr	ner: Scene	
n of Vi ding Physi a. After this	T:T	27. Manner of Death 1 Natural 5 Panel		of Injury 28b , Day,Year)	. Time of		ry at Work		d. Describe h				
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Division tal or Attendir as after death.	ertification:	deteri	not be	e of Injury - At home, house	tarm, stre	eet, factory, office t	oullaing, etc	. 28	or Jown S ockvil	tate) 32	W. I	Bural Route Nu Lamonst	OD.
Division of Vital Records, P.O. Box 68760, To the Bospial or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	O	29a. Certifier	1 1 1 21	st of my knowledge, d	eath occi	rred at the time. d.	ate and pla	- 1				ated.	
thin 24 the F	Medical	(Check only 1 Certifying Phone) 2 Medical Exam	niner:On the basis of and manners	of examination and/or	investiga	ation, in my opinior	n, death occ	curred at the	ne time, date	and place	e, and due to	the cause(s)	
8 7 8 7	B e	29b. Signature and title of certifier	with manner 5	1		29c. Licens	se number			29d. Da	ite signed (A	fonth, Day, Yea	ir)

State 31. Date filed (Morgh, Day, 297)
Registrar 2008

Margarita Korell MD.

Assistant Medical Examiner 32. Registrar's Signature

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 15, 2008

30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 1 2008

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2008 2068

		•	State Registrar			Certif	ficate of L	Death		F	Reg. No.	2000	20001
	Physici /Medic		1. Decedent's Name (First, Middle, Las Claud Edward Young					-		Date of Dea June		′ 2008 ^{ear}	3. Time of Death 07:45 A M
1	Examin	4-	4a. Facility Name (If not institution, give 5636 Dartmouth St.	reet		41	b. City, Town, or Churcht		Death		1	County of Death nne Arun	del
	Funeral Director		220 12 3177	7. Age X M 2 ☐ F	(In yrs. last bi	ii ii rowy/	f Under 1 Year Ionths Days	If Under 24 Hours	4 Hrs. 8 Min.	B. Date of Birth (Month, Day 06/29/	, Year) 1925	9. Birthp Cour Penn	place (State or Foreign ntry) sylvania
	e Maryland 3a-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar		10c. City, Tow Church	hton							1 ☐ Yes 2 No
	th with th 23a or 26 ust be no	al Dire	10e. Street and Number 5636 Dartmouth St	reet			10f. Zip Code 20733		-		Uni	ted Stat	es
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It has 23 a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2□ Married 3 🌠 Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 €			s Decedent of Hi es, specify Cuba Yes 2X No	ispanic Origi an, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- ican, etc.)		14. Race - Americ Black, White, Specify: Wh	
15-0	"natur	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	168	a. Decedent	t's Usual Occup d of work done o NOT use retired	ation during most o	of working	7	16b. Ki	ind of Business/In	dustry
2121	within iene. than	omp	Elementary/Secondary (0-12)	College (1-4or 5+	E		or Mecha				E1	evator R	epair
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any lipury or other traumatic event, the Me <u>once.</u>	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Claud Edward Youn	g, Sr.						First, Middle, Cecilia			
, Mary	and 2 shouselfth and Market 127 is market traumare		19a. Informant's Name/Relationship (7 Stephen Young/Son	ype. Print)								or Town, State, Zip Marylan	
Baltimore,	Pages 1 annual of He		20a. Nethod of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		cemete	ery, cremate	on (Name of ory or other place erans Ceme		Da 5/11/			cation - City or To tenham, Ma	
Balti	permit. Departn Importa any int		21. Signature of Emperal Service Licen	see						_			1 Home, P.A MD 21037
60,	Physician examiner be as the burial-transit e as the burial-transit	al Examiner	23a. Part1. Enter the disease, or compance, or heart failure. List only of the state of the stat	b. Due to (or as a Due to (or as a Due to (or as a	Fail Consequence	ore JUSCO of):	1)isec.	se				Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal deat		ctopic pregnancy ther (specify)	/				23d. Date of deliv Month	ery Day Year
	uires that signed by d be deta	by	Part II. Other significant conditions of	ontributing to death but	not resulting	in the unde	erlying cause giv	en in Part I.		23e. Did to			the cause of death?
Division or Vital Records,	The law requir cate has been si page 2 should b	Completed										death?	opsy findings available impletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be o	25. Was case referred to medical examiner? 1 ☐ Yes No	Hospital: 1 □ Inpatien	t 2□ER/0	hutnationt	3 DOA Oth	or:		(Check only o		a	
on or	ding Phys h. After this funeral dii	tion: To	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day	28b.	. Time of Injury	28c. Injur	4 L Nur	1	Bd. Describe h		6 □Other (Specing occurred	<u></u>
Divisi	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined		y - At home, f (Specify)	farm, street	, factory, office		28	Bf. Location (S City or Tox	Street ar vn, State	nd Number or Rur e)	al Route Number,
	To the Hospital within 24 hours and the Funeral completely filled	Medical (ysician: To the best of niner: On the basis of and manner state	examination a								
	Vithii vithii To th	ME	29b. Signature and title of certifier				29c. Licens	e number	/		29d. Da	ite signed (Month	Day, Year)
	DL46	P	1/ Mm		15 (I) ===		J US	8160	6		UU	ne Y,	2008
	10.10		30. Name and address of person who defined (Month, Day, Year)	1	3164 's Signature	Brai	verton s	St, 50	uite	101, 20	dgel	uciter, n	2008 40 21037
	Sta	ite	IIIN 1 0 200	18 Heres	K	Lan	1.0						

Physicia /Medica Examine

Funeral Director

For State Registrar			,	•	artment of F <i>rtificate of</i>		, ,	eg. No. 2	າກຂ່ວ	100
1. Decedent's	Name (First, Middl	le, Last)					2. Date of Deat	h	3. 11	me of Death
Harry		August		Zeigle	er		June 6	, 2008	Year 1:	42 p M
	me (If not institutio 35th Street	n, give street and nu	mber)		4b. City, Town, o	or Location of Deat ier	1		y of Death e George's	
5. Social Secu 719-16-3	*	6. Sex 1 本 M 2 ☐ F	7. Age (In yrs. 93	las <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Feb. 6, 1	Year) 9 15	9. Birthplace (S Country) Mar	tate or Foreig y 1an d
10a. State Maryland	10b. County	rince George		y, Town or Lo 1t. Rain						de City Limits
10e. Street an 4026	d Number 35th Stree	t			10f. Zip Code 207:	12	1	0g. Citizen of US	What Country?	
	atus Married 2□ Mar ved 4□Divorced	ried Armed F	2 X No ive	'	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Puer	pecify Yes or No- o Rican, etc.)	Bla	ce - American India ack, White, etc. fy: White	an,
	(Specify only highe Secondary (0-12)	nt's Education est grade completed) College ((Give life. L	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	king		Business/Industry	
	8 ame (<i>First, Middle,</i> V. Zeigler	Last)		Mec	hanic	18. Mother's Nar	ne (First, Middle, M	Railroa Maiden Surna		
19a. Informan	t's Name/Relations			19b. Mailin	ng Address (Street	and Number or R				
		3 □Removal from	State _ c	emetery, crer	osition (Name of matory or other pla	' Jur	Date ie 11,	20c. Location	- City or Town, Sta	ite
		Specify)	NO	κ_{κ}	сищии сель	erera:	-			_
21. Signature	of Funeral Service		RO	22	Name and Addre Francis J. 500 Univers	ess of Facility Collins Fu	neral Home	Inc.	e, Marylan MD 20901	E
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State Registrar

JUN 1 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Austin H. Arthur Jr. 1:00 AM June 2008 24 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5 Brett Court Baltimore Essex 8. Date of Birth July 24, 1923 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours 1**∑** M 2□ F Months 215-18-9675 84 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Brett Court 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White δ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Meat Smoker Esskay Co. 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Austin H. Arthur Sr. Anna E. Keissling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Kahler /daughter 648 Middlesex Road Baltimore MD 21221 Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hills Cemetery 6/28/08 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 Donayon 5 Dother (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. 21. Signature of Funeral Service Licenses MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. and Death Immediate Cause (Final **Physician** Metastatic Cancer HEAVI resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9☐Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? /es 2 No certificate 1∏ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours the Funeral Dire l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

2 6 2008

32. Registrar's Signature

30) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myo Min (N. D.) 9114 Philadelphia Road # 205, Baltimore, MDZ1237

D45390

June 20th, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar 20684 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death khonda Amola 0 8 a 12:10 AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Northwest Hospital Baltimore Baltimore 8. Date of Birth (Month, Day, Year) Aug. 13, 1960 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours Min. Germany 218-82-7937 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State MD Baltimore 1 ☐ Yes 2X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7746 Gough Street 21224 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Leon Lough Katheryn Barlow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1905 Chelsea Green DRive ViginiaBeach VA Velinda Watson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Removal from State Bayview Crematory 6/20/08 Baltimore MD 4 □ Donation ; 5 □ Other (Specify) un fal Service License 21. Signatu 22. Name and Address of Facility 300 MAce Ave.Balto. MD 21221 Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complication what caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) ervicalcan Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate Due to for as a consequence of if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 2 🗌 No 4 Unknown 1 Yes 24a Was an

Examiner Examine attending physician and for use as the burial-trar burial-trai the s been signed by the should be detach has this

Physician/Medical

Completed by

Be 2

Certification: To

Medical

P.O. Box 68760.

Division of Vital Records.

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any Injury or other traumatic event, Its Medical Examples.

Physician /Medical

Baltimore, Maryland 21215-0036

the Medical Examinar must be notified at

Director

Funeral

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the Hospital or Attending Physician: The law requires that the death certificate be executed s after death.
I Director: After this
of in by the funeral d To the Hospital o within 24 hours aft To the Funeral Di completely filled in

						autopsy performed?	prior to completion of cause of death? 1 □ Yes 2 ◯ No
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3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	d not be rmined 28	e. Place of Injury - At h building, etc. (Special	ome, farm, street	, factory,	office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
						e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)

29c, License number

29d. Date signed (Month, Day, Year)

ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add

am 23a) (Type, Print)
That Reistentium, MD

State Registrar

32 Registrar's Signature 31. Date filed (Month, Day

and manner stated

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 20685 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6-25-2008 **Physician** 3:47AM M Doris M. Alcamo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cranberry Cottage Asst. Living Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-30-1930 9. Birthplace (State or Foreign Country)
Md • 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 □ M 2√2 F 77 215-28-6424 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f sh other traumatic event, the Medical Examiner must be notified a 1 ☐ Yes 2√ No Director Md. Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral <u>9421 Dawn Dr.</u> 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, GiveX Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No þ Specify: X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ William Watson <u>Josie Irvin</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any Injury or other trauonce. 904 River Falls Ct. Jean Browning DTR. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Ma Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-30-2008 <u>Baltimore National</u> _Balto. 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause an each line. Immediate Cause (Final Physician heumia disease or condition resulting in death) /Medical Examiner V0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed I went a attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 → Nor 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy performed certificate 1□ Yes 2 100 To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Ather (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and mariner stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) ID 30. Name and address of person who completed cause of death-(Item 23a) (Type, Frint) Go baty m) MARWA 31. Date filed (Month, Day, 32. Registrar's Signature Year) 5 Registrar

10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian Black, White, etc. Specify: White 16b. Kind of Business/Industry <u>Tailor Shop</u> 18. Mother's Name (First, Middle, Maiden Surname) Wilkenson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1138 Paul Martin Dr. Edgewood, Md. 21040 20c. Location - City or Town, State Oak Lawn Cemetery 6/26/08 Baltimore, Maryland 22. Name and Address of Fack aczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md 21222 Approximate Interval Between Onset and Death MINUTES 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) JUNE 23, 2008 D043 Bay 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Greenough II and Baltimor Year) 2008 31. Date filed (Month, Day, 32. Registrar's Signature JUN 2 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Birthplace (State or Foreign Country)

To the Hospital of within 24 hours all To the Funeral D

State of Maryland / Department of Health and Mental Hygiene, 20687 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2008 Physician June 10. 12:01 PMM Lea Evans Ash /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Annapolis Anne Arundel Heritage Harbour If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F Oct 25, 1940 Georgia 256-60-8482 67 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Director MD Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2700 S. Haven Road 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white ģ 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within Elementary/Secondary (0-12) College (1-4or 5+) administrator <u>non profit</u> permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 is marked other i any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Howard Evans Ruby Loyless ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Amanda Freeland/daughter 908 Blue Ridge Road Annapolis, MD Baltimore. Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Laneral Service Li State Anatomy Board 655 W. Baltimore Street rector Baltimore, _MD 21201 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedia ause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed bunial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes ned by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 T. No 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) this al or Attending Physical States death.

In Director: After this of in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 □Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determine 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in I Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ecly Len 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day "Month 2:37 PM Sther Bishott 7003 SILLY Johns Hockins Boyview Medical Center 5. Social Security Number 6. Sex 7 April 19 4b. City, Town, or Location of Death 4c. County of Death Battimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min Months 1□M 2**X**F Days Hours 212-18-7425 86 MD Oct.21,1921 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Baltimore Baltimore MD 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 7300 Fait Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛱 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Foehkolb Mary Eye 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Bishoff Jr. /son 7300 Bridgewood Drive Baltimore MD 21224 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Sacred Heart of 1

Burial 2

Cremation 3

Removal from State Jesus 6/25/08 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave, Balto. MD Connelly Funeral Home of Essex 21221 23a. Pagt 1. Enter the disease, or complications that caused the deshock, or heart failure. List only the cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Failure Heart me hour Due to (or as a consequence of): Actery Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Thrombosis 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DER/Outpatient 3 □ DOA Yes 2 No 1 | Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

requires that the death certificate be executed use as the burial-tran Box 68760, physician for P.O. ed by the a detached f been signed be should be deta Division or Vital Records, N page certificate Physician: funeral director, After this

Hospital or Attending

death.

hours after death uneral Director: filled in by the

within 24 hours a

completely

Physician/Medical

Completed by

Be

Medical Certification: To

1 Natural

2 Accident

3 Suicide

29a. Certifier

one)

4 Homicide

(Check only

9 Unknown

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and tipe of certifier

JUN 2 6 2008

filed (Month; Day, Year)

5 Pending

investigation

6 Could not be determined

29c. License number D40642

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

EASTERN AVENUE, BALTIMORE, MD. 21234 MIKIN 4940 PLE OBRIC Date filed (Month: Day MD 32/Registrar's Signature

Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Dav WILLIAM ARTHUR BENEDETTO JUNE 24, 2008 0835 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL ATR HARFORD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Days Hours 1X M 2 ☐ F 213-12-0994 84 Oct. 29, 1923 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Harford Bel Air 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 623 Derringer Drive 21015 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Supervisor</u> Petroleum Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony Reardon Benedetto Beatrice Victoria Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Candida Benedetto / Wife 623 Derringer Dr., Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air Memorial Grdn. 6-28-08 Bel Air, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final BEUMONIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIAPLETES MELLITUS, TYPE 2 1 Yes 2 No 3 Probably 4 Unknown ISCHEMIC HEART DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy CARDIO MYDPATHI performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1. ♣ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Lacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDROW NOWAKOWSKI MID 35 FULFORD AVE. BOLAIR, MID 2/014

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D08096 DUNE 24, 2008

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

Completed by

Be

Funeral

Director

If item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

al Hygiene.

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Department of Health and Mr Important: If item 27 1-any Injury or c."

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the burial-tran and

funeral 24 hours after death e Funeral Director: filled in by the

Physician/Medical Completed by Be Certification: To

Medical

State

1 Natural

2 ☐ Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

5 Pending investigation

6 ☐ Could not be

JUN 2 6 2008

Andew Howoliowser MD

A Registrar's Signature

Examine

Vital

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Division

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28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 1 tem 26 per doc 9880 6-26-08 vt amend 1 tem 5 per fh g882 8-26-08 vt State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician BROWN NNI TUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not Institution, give street and number) Examiner 4VENUE MORE MONDS 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
NORTH CAROLIN 24313481184 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 1 □ M 2 🕱 F CAROLINA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, I'm Medical Ever. in it in ust be notified at 1 Yes 2 No Director MARYLAND 10g/ Citizen of What Country? 10f. Zip Code 10e, Street and Number by Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after or and Mental Hygiene.

Is marked other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SEWING STRESS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If item 27 Is marked ot, any injury or other traumatic encones. Be 1CHARD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTER VORK 11434 MITCHEL 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mik. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the burial-tran and Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Dav 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Onknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a 0060 June 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pultury MD. 2120-1303. 31. Date filed (Month, Day, Year) Registrar's Signature 32. State Registrar

DHMH 17 Rev 1/2001

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Anne

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, nty of Death onta If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Coultry) Hours Months Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No aure 10g. Citizen of What Country? 10f. Zip Code 20708 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: **Blact** 3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Towel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Hollan 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) Koad elma 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 301 to., Md. 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other/significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 1100 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Hospital: 1 ☐ Yes 2 1 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Box 68760, physician s the burial attending ph ed by the a P.0. icate has been signed , page 2 should be det Division of Vital Records, this certificate h

After this funeral c

n 24 hours after death. e Funeral Director: Aft eletely filled in by the fun

To the I

Physician

/Medical

Physician /Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

\$

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Marical Examinational Leancified at once.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical þ Completed Certification: To

Medical

State

Registrar

IF FEMALE: 23b. Was decedent pregnant

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier (Check only one)

28b. Time of Injury Date of Injury (Month, Day, Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 24/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

and manner stated.

HIA 31. Date filed (Month, Day, Year)

investigation 6 Could not be determined

> 2 6 2008

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ADYUUN /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BaltIMORE owson 7. Age (In yrs, las If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Jountry) last birthday) Social Security Number **Funeral** Months 1 □ M 2 X F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County Baltimore 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, To Be Sherman 19a. Informant's Name/Relationship (Type-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherman Conigland 5921 Brother Leewood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Tarrison 3 □Removal from State 1 Burial 2 □ Cremation 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License of Facility Green Balto. Md 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebra **Physician** ascular disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if arry, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy Month Day signed by the at Id be detached for 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Honknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑No 24a. Was an page 2 s autopsy performed 1□ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 1 ☐ Yes 2 000 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred After (Month, Day Year) Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, within 24 hours after death.

To the Funeral Director: / To the Hospital

> State Registrar

(Check only one)

31. Date filed (Month,

29b. Signature and title of certifier

Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

H0054424

Timenum Nol. # 209 Timenium, MD 21093

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

20694

		1 = For State Registrar	0,0.0	ary tarrar =	Certificate	of Death	,	Reg. No.	2 20034
		1. Decedent's Name (First, Mid	idle, Last)	·			2. Date of De Month	eath Day Yea	3. Time of Death
Physic /Med		Charles	Bedone				6	19 08	
Exami		4a. Facility Name (If not institut	ion, give street and number)		4b. City, Tov	wn, or Location of D	eath	4c. County of De	ath
		Cromwell	Genesis			le a 14		Back	irmore
Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birt	hday) If Under 1 Y Months D		Min. (Month, Da	rth 9. B ay, Year) (irthplace (State or Foreign Country)
Director		232-52-3553 Usual Residence of Decedent	1	74			June 28	5, 1933 We	st Virginia
land ow		10a. State 10b. Cour	ıty	10c. City, Town	or Location				10d. Inside City Limits
Many H sh	tō	MD Balti	more	Balti	imore				1 ☐ Yes 2√∑ No
ith the Marylan or 28e-f show	irec	10e. Street and Number			10f. Zip Co	de		10g. Citizen of What	Country?
th wit	Funeral Director	12905 Cunning	hill Cove Roa	ıd		21220		USA	
r dea	iner	11. Marital Status	12. Was Decedent Armed Forces?	?	13. Was Deceden If Yes, specify	t of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	o- 14. Race - Ar Black, Wi	nerican Indian, hite, etc.
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Itams 23a or 28e-1 show ant, tra Medical Everthrer must be notified at	by Fu	1 Never Married 2 M	If Yes, Give	*53 – 55	1 ☐ Yes 2 X			Specify: W	hite
5-0036 72 hours all naturell, or	ed b	3 Widowed 4 Divorc	ed Year or Dates:		Decedent's Usual C	occupation		16b. Kind of Busines	ss/Industry
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arylar should b ind Ments marked	10 6	John Boyd Bed	ckner				Adeline P		
Maryland d 2 should be file th and Mental Hy 27 is marked oth traumetic event	1	19a. Informant's Name/Relatio						per, City or Town, State	
e, M 1 and 3 Health em 27 sther tra		Ann Beckner/sp	ouse ———————					Baltimore,	
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or itams 23a or 28e-1 show any injury or other traumetic event, the Medical Exercipation to the millised at once.			ce Licensee S. Wade, Dir	ector	State An	Address of Facility atomy Boa	ard 655 W.	. Baltimore	Street
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/Medical Examiner		Tooling in addition	Due to (or as	a consequence of	of):				0
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b, P.O. Box that the death cer ned by the attendir e detached for use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	e of pregnancy 2 Fetal death	3 ☐Ectopic preg	nancy		23d. Date of Month	delivery Day Year
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on on ding Figure 1. After a funera	tior	1 ⊟Hatural 5 □ Pen 2 □ Accident inve	28a. Date of Injunding (Month, Date of Injunding)	ay Year) li	njury M	Work? 1 ☐ Yes 2 ☐ No			
Division of Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Cou	ald not be 28e. Place of In	jury - At home, fa	rm, street, factory, o	ffice	28f. Location	(Street and Number or own, State)	Rural Route Number,
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Div	9		fuing Physicians To the heat	t of my knowledge	e, death occurred at	the time, date and p	place, and due to the occurred at the time	e cause(s) and manner e, date and place, and	r as stated. due to the cause(s)
Hospital or 14 hours afte Funeral Dir tely filled in I		(Check only 2 Medic	cal Examiner: On the basis of	or examination an	are investigation, in				
Di o the Hospital or thin 24 hours afte o the Funeral Dir mpletely filled in I	Medical Ce	(Check only 2 Medicone)	cal Examiner: On the basis of and manner st	or examination an		icense number		29d. Date signed (M	
Division of Vital Re To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate the completely filled in by the funeral director, page	edicai	(Check only 2 Medicone) 29b. Signature and title of cert	cal Examiner: On the basis of and manner st	tated.	29c. L	icense number			onth, Day, Year)
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To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edicai	(Check only 2 Medicone) 29b. Signature and title of cert	cal Examiner: On the basis of and manner st	tated.	29c. L	icense number	- 70 ws ~	29d. Date signed (M) (0/16/-	onth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 20695 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Blanchard, 3rd William Henry June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore-Washington Medical Center en Knr nny If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 31, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year 1917 **Funeral** 1 ₹ M 2 □ F Maryland 91 215-10-6957 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exemined must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1206 Nottingham Drive United States Funeral 21061 12. Was Decedent Ever in U.S. Armed Forces?

1 No Yes 2 □ No 1944 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laura Amelia Hess William Henry Blanchard, Jr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21061 Dorothy Kinnard / Daughter 7947 Piper's Path Glen Burnie, MD Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 26086, 1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery Brooklyn Park, MD 5 ☐ Other (Specify) 4 ☐ Donation 21. Signatur Funeral Service Licensee Kirkley-kuddick Funeral Home, P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) X **Physician** /Medical Due to (or as a consequence of): Examiner 1 Unan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit Due to (or as a consequence of): Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) □Yes 2□No P.O. ned by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2√No 3 Probably 4 Unknown this certificate has been si al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □Vo 24a. Was an autopsy 1 ☐ Yes 2 No Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Impatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide filled 24 hours a TSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated. the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

30. Name and ad 16 ss of person who I mpleted cause of death (Item 23a) (Type, Print)

			Pleas	e Type or Prir							•		.egible.	
			1 - For State Registrar	State of Ma	arylan		partme <i>Pertifica</i>				, ,		2008	20696
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	Examir		4a. Facility Name (If not institution,					, Town, or	Location	on of Death		4c. C	County of Death	
-	Francis		5. Social Security Number	Avenue 7. Aqu	e (In yrs. I	ast birthd	lav) If Und	er 1 Year	م کر If Und		Date of Birt	h		N/A place (State or Foreign
	Funeral Director		103-22-5602 Usual Residence of Decedent	1 □ M 2 X □ F	80	Yrs	Month:		Hou	's Min.	B. Date of Birt (Month, Da 10/26	/192	7	GERMANY
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	3a or	a Di	2100 WEST ROGE	RS AVENUE			10	.,	21:	209		rog. Oile	USA	,
	items ?	Funeral	11. Marital Status	12 Was Decedent F	Ever in U.	S. 1	I3. Was Dec	edent of H ecify Cuba		Origin? (Spec can, Puerto Ri	ify Yes or No-	1.	4. Race - Amer Black, White,	
215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Everning or must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	Armed Forces? d 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	10		1 □Yes		Spec				Specify:	WHITE
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Maryland 2	Mel arke	မ	PETER	/Time Drint)			LK	e /Stroot		ETTINA	Davita Niverb	- City as	Town, State, Z	ILLER
	and 2 sho lealth and m 27 Is ma her trauma		19a. Informant's Name/Relationship ALEXANDER BAR		T	59	16 KE	AVE	NUE	, BALTI	MORE,	MD	21215	·
Baltimore,	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe				sposition (Nation of FILOH			Dat 06/23/			ation - City or T	
Rait	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Li	ensee	•		22. Name a						& BROS. SVILLE,	, INC. MD 21208
	Physician		23a. Par 1 Ent if the disease of she in the disease of lamediate Cause (Final disease or condition	ily one cause on each lir	the death	1	enter the mo	ode of dyin	g, such	as cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
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0	J Phys er this eral dii	1: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry T	28b. Time		28c. Injury Work	4 🗆		d. Describe h		Other (Spec	ify)
0	ath. r: Afte re fune	atior	1 Natural 5 Pending 2 Accident investigat	(Month, Da)	i, Year)	Injur	ry M		? Yes 2	_		,		
DIVISION	al or Atte s after de il Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ry - At ho	me, farm,	street, facto	ry, office		28	f. Location (S City or Tow	treet and n, State)	Number or Ru	ral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of caminer: On the basis of and manner sta	examinat	wledge, de tion and/o	eath occurre	d at the tin	ne, date	and place, ar death occurred	d due to the	cause(s) a	and manner as place, and due	stated. to the cause(s)
	To the vithin to the complex c	Me	29b. Signature and title of certifier	an			2	Oc. License					Signed (Month	, Day, Year)
	10		30. Name and address of person wh	no completed cause of de	eath (Item	23a) (Typ	pe, Print)	hst.		B~ (+)	NO M. M.			<u> </u>
	Sta	te	31. Date filed (Month, Day, Year)	22. Registra	ar's Signat	ure	9 000	1 '	/	U~ 11"	,			
	Registr	ar	JUNE 6 Z	IUO planes	D.	Ro	and it							
DHN	/IH 17 Rev 1/2	001				•								

Reg. No. 2008 20697 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 20 ay 2008 **Physician** 5:55pm Anna P. Clemons /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Middle River Baltimore Ivy Hall Nursing Center 8. Date of Birth (Month, Day, Year)
Time 10,1928 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 216-28-8494 1 ☐ M 2 🔀 F Yrs. 80 WVA Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√☐ No Baltimore Baltimore MD Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21222 276 St. Helena Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 21X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental F permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any linjury or other traumatic evonce. Clarence Calvert Goldie Stone ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 384 Forest Hills Blvd. Naples FL 34113 Don Clemons /brother-in-law 20b. Place of Disposition (Name of cemetery crematory or other place)
Druid Ridge Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial P₁ Cremation 3 ☐ Removal from State Baltimore MD 6/27/08 5 Other (Specify) 4 Donetia ral Service Lic 22. Name and Address of Facility 22. Name and Address of Facility 300 Mace Ave. Bal Connelly Funeral Home of Essex Balto, MD sex 21221 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pulmonary hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as nding IF FEMALE: esn 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant atten 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 menths? Month Day Year 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 tiboillation nal 1 es 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has page certificate 1□ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2X No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 1 ☐ Yes Certification: To this 27. Manner of Death 28b. Time of 28a Date of Injury 28c. Injury at 28d Describe how injury occurred After 1 (Month, Day Year) To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation within 24 hours after common to the Funeral Director: After money filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0062194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

hintan

JUN 2 6 2008

31. Date filed (Month, Day, Year)

Desai Registrar's Signature 21202

08-04778 Albert Cloutier, Sr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 20698

ibe	rt Glootler, Gr	1.	For State Certificate of Death			eg. No.	
	Physicia		eqistrar . Decedent's Name (First, Middle,Last)		2. Date of Dea Month	Day Year	3. Time of Death 0552 hrs
P	ا Examin	er	Albert Cloutier Sr.		June 21, 2		
1		4	Ra. Facility Name (ii not institution, give substanta harman)	n, or Location of Deat	h	4c. County of Baltimore	
			Frankiin Square nospital		e 8 Date of Bi		9. Birthplace (State or
	Funeral	- [5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Days Hours Mir			Foreign
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		-	Usual Residence of Decedent 10c. City, Town or Location				10d. Inside City Limits
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	Aaryland 28a-f show 1 at once.	힐	Let it a			10g. Citizen of Wha	at Country?
	Mary 28a-	Director	Tige. Street and Number	220		USA	
	death with the Maryland or items 23a or 28a-f sho must be notified at once.		The state of the s	of Hispanic Origin? (Specify Yes or N		American Indian, Black,
	th wit	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify C	uban, Mexican, Puer	to Rican, etc.)	White,	etc.
		ᇍ	1 Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2	No specify:		Specify:	
	rs afte	[출	Tor Dates:	cupation (Give kind o	f work done	16b. Kind of Bus	iness/Industry
	2 hou "nat	핡	Elementary/Secondary (0-12) College (1-4 or 5+) Electrica		etired)	GM	
	hin 7. hin 7. e. than	힏	6th				
	15-0036 filed within 72 hours after death with the Maryland I Hygiene. I other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Nar	ne (First, Middle	, Maiden Surname)	
	21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner	B	unknown	unkr	own	- Dit on Tour	State Zip Code)
	21 ould dead of Mer s ma	의	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address				
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	ages 1 and 2 nt of Health it: If item 2		Crematory or other place)		5/25/08	Dol+	imore MD
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	Baltimore, permit. Pages I a Department of He Important: If ite injury or other ti		21. Spriature of Purieral Service Literature	3			Balto. MD
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	[□] hysician Viedical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascula				Between Onset and Death
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			Sequentially list conditions, b				
		ner	for my leading to immediate Cause. Enter Underlying Cause				
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	tal Records, P.O. Box 68760, cinn: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit	dical	UNPENDED AMENDED				
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	nding nh. r: Af	lion	1 Natural 5 Pending (Month, Day,Year)	1 Yes 2 No			
	ivision or Attend after death. Director:	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory,	office building, etc.		on (Street and Numl m, State)	ber or Rural Route Number, City
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	To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.				ned (Month, Day, Year)
	FSFÖ	ğ		O.C.M.E.		June 21, 2	
1	4		fail of mis	J.U.IVI.E.	·	33110 21,	
	1.		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn S	treet, Baltimore,	MD 21201		
_	W		Tastia Ciccinory III.				
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hmore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, TAN. 31 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1**⊠**M 2□ F Yrs VLAND Director MAR Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director MARILAND 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number # APT. 1106 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗷 No 1 ☐Yes 2 No Be Completed by 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I amy injury or other traumatic event, the Mad gones. Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (いんべいないい) ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SISTE KOAD WIL Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State EME 07-01-08 BALTIMORE MARYLAND JE. FUNERAL HOME 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee BALTO, MO. 21211 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** carara disease or condition resulting in death) /Medical Due to (or as a consequence of): 7510× Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner that initiated events resulting in death) Last Due to (or as a consequence of) 68760, The law requires that the death certificate as IF FEMALE: Box 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🔲 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy certificate 2 No 1 ☐ Yes 2 ☐ No Vital To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To oţ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 70 land 31. Date filed (Month, Day, Year 6 32. Registrar's Signature State Registrar

08-04783 George Dotterweich, III Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 20700

	9			For State Certificate of Death	7			Reg. N	0		
	Physici	ian/	_	gistrar Decedent's Name (First, Middle,Last)			2. Date of De Month	Day	Year	;	3. Time of Death 1029 hrs
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_	Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending.	dwo	Medical	and manner stated.			at are time,	_			onth, Day, Year)
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~				Mayone The Will	J.C.IVI.	<u> </u>					
				 Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn St 	treet Balti	imore. M	D 21201				
		Sta istr		31. Date filed (Month, Day, Year) JUN 2 6 2608	•						

State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 5:40AM M June 20 2008 Joseph Anthony Dobry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hospice Stella Maris Baltimore Timonium 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 ☑ M 2 🗆 F Director July 6,1920 215-12-5275 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show other traumatic event, the Wedical Examinary and be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Maryland Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1 Nacelle Road 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1, ☐ Yes 2 ☐ No I≰Yes, Give Year or Dates: WWII items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐XNo Specify. Specify: þ 3 Widowed 4 Divorced White "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Heavy Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I Joseph Anthony Dobry Mary Dvorak ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Nacelle Road Middle River, Maryland 21220 Mrs. Dorothy G. Dobry/ Wife Health tem 27 Important: If item any injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 6/26/08 Hilltop Service Corp. Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ABDOMINAL CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine burial-transit be executed and resulting in death) Last Due to (or as a consequence of) Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Lectopic pregnancy Month Year 4 Pregnant at time of death signed by the a d be detached fo 5 Other (specify) P.0. Tyes 2 TNo 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed certificate 1 ☐Yes 2 XNo 1 ☐ Yes 2 ☐ No Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred After Hospital or Attending 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death. neral Director: A filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manyer stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10X 30. Name and address of person who completed cause of death (Item 23a, rype (Print) ERNESTINE WRIGHT 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 2 6 2008 Registrar

2008

JOSEPH DOBRY

			1 - State Amend Items 4	State of Marylands of 29d per d	and / Depa r.,g880	artment of H	ealth and M dhb <i>eath</i>	lental Hy	gien 2 () ()	8 20702
	3		Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	Physici /Medio		Katherine E	Jullea				Sune		Year
	Examir		4a. Facility Name (If not institution, give of	eet and number)	60	46. City, Town, or 12070 Rei	Location of Death	RJ	4c. County o	Death LIMOV
100 mg	Funeral Director		5. Social Security Number 6. Sex 101	7, Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan 15	y, Year)	9. Birthplace (State or Foreign Country) Maryland
	*		Usual Residence of Decedent					0 411 15)		
	Manylan I-f ehow Iied at	tor	MD 10b. County Carroll	10c.	City, Town or Lo Hamps					10d. Inside City Limits 1 ☐ Yes 2 No
	or 28e	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
	ath wi	ralD	1121 M. Main Street				21074		USA	
936	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow or other traumatic event, the Marylan Examinate in notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🏋 Divorced	. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2ሺ No	spanic Origin? (Spi n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black	- American Indian, White, etc. White
21215-0036	2 should be filed within 72 hours aft nand Mental Hygiene. Is marked other than "natural", or raumatic event, Ita Mudical Exert	Completed	15. Decedent's Educa (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of work.	ng	16b. Kind of Bus	iness/Industry
212	giene grene er tha	TO.	Elementary/Secondary (0-12)	College (1-4or 5+)	s	ecretaria	1		Westing	ghouse
pu	be file ital Hy d oth	Be	17. Father's Name (First, Middle, Last)	-					, Maiden Sumame)
Z	d Men narke	2	Charles Warren Doy 19a. Informant's Name/Relationship (Type		10b Mailie	ng Address (Street a	Agnes De			itate. Zin Code)
Maryland	od 2 sl Ith and 27 is r traur		Susan Markus/daug	•		terwal Ct				_
Baltimore,	permit. Pages 1 and 2 Department of Health a important: If item 27 is ony injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 4 ※Donation 5 ☐ Other (Specify)		o. Place of Dispo		! .	Date		City or Town, State
Balti	permit. Departminents imports eny infu		21. Signature of Funeral Stryice Licensee	de, Direct	or St	Name and Address ate Anato 1timore,	s of Facility my Board MD 2120		Baltimo	re Street
	2		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	itions that caused the di cause on each line.				or respiratory a	rrest,	Approximate Interval Between
6	Physician		Immediate Cause (Final disease or condition	Metasta	1	Breast (_			Onset and Death
***	/Medical Examiner		resulting in death)	Due to (or as a cons						
*	ZX	_	Sequentially list conditions, b.	Due to (of as a cons	sequence un.					
	uted 3 ansit	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	250 10 (0: 20 2 20:	3423.1133 317.					
oʻ	sate be executed obysician and the burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a cons	sequence of):					
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9	entifica ing ph e as ti	Med	IF FEMALE:							
P.O. Box	the death certificate be executed y the attending physician and iched for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 IMO 9 Unknown	c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
	law requires that the de as been signed by the a 2 should be detached	by	Part II. Other significant conditions contr	ibuting to death but not	resulting in the u	nderlying cause give	en in Part I.			bute to the cause of death? 3 Probably 4 Unknown
Records,	The lay	Completed							psy pr prmed2 de	fere autopsy findings available for to completion of cause of sath? Yes 2 \sum No
/ita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?				26. Place of Deat	n (Check only	one)	
of	Physi this c	T	1 ☐ Yes 2 ☐ No Ho 27. Manner of Death		ER/Outpatien		4 Nursing no		dence 6 Other	
LO	e fe	tlon	1-Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Worl	Yes 2 □ No	280. Describe	how injury occurre	d
Division of Vital	or Attending ster death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, str			28f. Location (City or To	Street and Numbe wn, State)	r or Rural Route Number,
	To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: A completely filled in by the fu		(Check only) 2 Medical Examine	cien: To the best of my	knowledge, deatl	n occurred at the tin	ne, date and place, pinion, death occur	and due to the	cause(s) and man	ner as stated.
	To the within 2 To the complet	Medical	29b. Signature and title of centiler	and manner stated.		29c. License	number		29d. Date signed	(Month, Day, Year)
	₹ <u>₹ 8</u>		DIVO NIA			D005			June 12,	
			30. Name and address of person who com	pleted cause of death (Item 23a) (Type,	D-1-A)			1 .	
_			Dorothy Seay,	5 am	25 Ma	in Street	Sinte ?	100 Ke	sterstow	n, Md 21134
美	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si						
	Registi	ar	JUN 2 6 200	O Received	1 4	rew.				

			For	State of Maryland /	Department of F	lealth and Me	ental Hygien	SUUS	20703
		-	State Registrar		Certificate of	Death	Reg. N	<u>.</u>	20103
			Decedent's Name (First, Middle, Last)	1		2	2. Date of Death	av Year_	3. Time of Death
	Physici /Medic		John E	dwards			Month -23	1-2008	8:55 AM
	Examin		4a. Facility Name (If not institution, give st	eet and number)	4b City, Town, o	r Location of Death	4	c. County of Death	
			8 KOCKY	Lane	Pike.	sville		Dalti	riore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last i		If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Yea.	9. Birth	olace (State or Foreign ntry)
	Director	į,	130-25-1100	w 2□F 84	Yrs.		08-28	-1723	NC
	and *	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	Aaryti Sho	ō	111 201114	nore Pik	esville				1 Yes 2 No
	the N	Director	10e. Street and Number	101 - 114	10f. Zip Code		10g. C	itizen of What Cou	ntry?
	with a or	۵	& Bocky Lo	ne		308		LISA	•
	death with the Maryland ms 23a or 28e-f show rinnst be miffed at	Funeral	11. Marital Status	2. Was Decedent Ever in U.S.		-	ify Yes or No-	14. Race - Ameri	
_	or Item	Fun	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No	13. Was Decedent of H If Yes, specify Cuba		ican, etc.)	Black, White	etc.
2	hours a turel', or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify: B	ack
2-003c	d within 72 hours after death with the Marylan jiene. r than "neturel", or Items 23a or 28e-f show	Completed	15. Decedent's Educa		6a. Decedent's Usual Occup	pation		Kind of Business/Ir	ndustry
7	within 7 ene. than "n	ble	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retired	d)			
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2	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)	1-		18. Mother's Name			
<u> </u>	ould b Menta varked vetice	၉	James Ed	wards		Maga		illian	
	2 sho and h is ma		19a. Informant's Name/Relationship (Type	1 1 1	9b. Mailing Address (Street	and Number or	- 1 -		
Ξ	コチトサ		Charlene Gree		5105 Bear	Deri 440	int Gre	ensboro,	NC 27455
e,	- I O =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	como	of Disposition (Name of stery, crematory or other place	ce) Da		Location - City or T	
Ĕ	Pages nent of ent: if it ury or o		'4 □Donation 5 □Other (Specify)	far	nison Fores	+ 06-2.	5-08 DU	vingsm	NS, MD
altimor	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licenses	11		ss of Facility VOU	ynn c.	Green	? Huneral Sna
מ	8 9 E 8 8		Vallythe L.	B _	8728 Lib			Is-town,	MDZ1133
			23a. Part1. Enter the disease, or complic shock, or he if failure. List only one	ations that caused the death. D	o not enter the mode of dyir	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician	. 1	Immediate Cause (Final disease or condition	conjunctivi	e heart	SAIlme		5/10	Onset and Death
	/Medical		resulting in death)	Due to (of as a consequence	ce of):	JAMAC	1 3/2)		
	Examiner		A Company of the Comp	helper ter	sion				
		je	Sequentially list conditions, if any, leading to immediate	Due tur a a consequence	ce of):				
B	cuted vd ransii	Examln	cause. Enter Underlying Cause (Disease or injury that initiated events						
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2/PU	cate be executed physician and the burial-transit	dical	d.						
٥	ntifica ng ph as ti	Med	IF FEMALE:			· · · · · · · · · · · · · · · · · · ·			
X P P	th ce lendii r use	an/l	23b. Was decedent pregnant	 If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 		y		23d. Date of deliver Month	very Day Year
	dea od fo	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of death 9☐Unknown	5 ☐ Other (specify) _			WORK	Suy Tour
7. O	at the by the	Physician/Me	9 🗆 Unknown				oo. Bidaabaa		the anyon of death?
_	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	þ	Part II. Other significant conditions cont		ig in the underlying cause giv	en in Part I.			the cause of death?
2	equir en si ould	fed	hyperten sion	1			I Yes	2 3 1 10	Dably 4 Donkhown
VITAI Mecords,	law n as be 2 sh	ple	0000				24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
Ĕ	The ate h	Completed	- /				performed	death? No 1 ☐ Yes	2 No
<u>e</u>	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical			26. Place of Death	(Check only one)		
>	ysic is ce direc	10	examiner? 1 Yes 2 No	spital: 1 Inpatient 2 ER/	Outpatient 3□ DOA Oth	ner: 4 🗌 Nursing Hom	e 5⊿Residence	6 ☐Other (Spec	ify)
0	ding Ph. h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28t (Month, Day Year)	b. Time of 28c. Injury Wor	ry at 21	8d. Describe how in	jury occurred	
UNISION	ath. r: Af	atle	2 Accident investigation			Yes 2 □No			
<u> </u>	er de recto by th	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, factory, office	2	8f. Location (Street City or Town, Sta	and Number or Ru. ate)	ral Route Number,
5	tel or s aft el Dii	Certification:		3					
	hour hour uner ly fill		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	cian: To the best of my knowled er: On the basis of examination	dge, death occurred at the ti	me, date and place, a	nd due to the cause	(s) and manner as	stated. to the cause(s)
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director. I	Medical	опе)	and manner stated.					
	To 1 To 1	2	29b. Signature and title of certifier	0.1.	29c. Licens			Date signed (Month	, vay, rear)
			Laureny	2 Wiles	MP DO	022090 Nop		127/2	08
			30. Name and address of person who con	ipleted cause of death (Item 23	a) (Type, Print)	1 /	1-1	/	
	•		LAWFORD D L	veler		Nor	1701		
	Sta Registi		31. Date filed (Month, Day, Year)	a2. Registrar's Signature	Small)	-			
		7-10	0 011 21 0 2000	DIMERCAL PROPERTY AND	AMERICAN PROPERTY OF THE PROPE				

			For State Registrar		S	state c	of Mary	land / D		rtmen tificate			ind M	ental H		ne No. 2 (008	20	704
F	Dhi.i		1. Decedent's Name	e (First, Middle,	Last)									2. Date of Month	Death			3. Time of	Death
	Physicia /Medic		A	lberta					E	aves				June		, 200		7:30	AΜ
\$	Examin		4a. Facility Name (/		-							Location o				4c. County	of Death		
	Market James and Market States		105 S 5. Social Security N	. High	lan	d Ay	venue	yrs. last bir	theloud	If Under		imor		8. Date of	Rirth		Q Right	place (State o	r Famian
	Funeral Director		220-22-		o. Sex 1 ☐ M	2 - F	1		Yrs.	Months	Days	Hours	Min.	(Month, 8-16	Day, Ye		Cou	ntry)	ir Füreigin
	- A.A. (C)		Usual Residence of				8	9						8-16	-19	10	ren	nesee	
	yland yow at		10a. State	10b. County				c. City, Towr										10d. Inside Ci	
	a-f sh	to	Md				В.	altim	or	e								1 XYes	2 □ No
	or 28)ire	10e. Street and Nu	mber						10f. Zip					10g.	Citizen of \		ntry?	
	23a ust b	la I	105 S.	Highl								224					S.A.		
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral Director	11. Marital Status			Armed Fo		in U.S.	13. \	Nas Deced f Yes, spec	tent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe i, Puerto	ecify Yes or Rican, etc.)	No-		e - Ameri ck, White,	can Indian, , etc.	
20	s afte	by F	1 ☐ Never Marr 3 ☐ Widowed		ed	1 ☐ Yes If Yes, Gi Year or E	2 No ive ive			1 ☐ Yes 2	2 X No	Specify:				Specify	«Whi	te	
0000	hour tural		3 🗆 widowed	15. Decedent's	s Educati		Jales.	16a.	Deced	ient's Usua	al Occupa	ation		-	16b	. Kind of B	usiness/Ir	ndustry	
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5	Pages 1 al		20a. Method of Disposition 1 Burial 2	position □Cremation	3 □Rem	noval from	State	20b. Place of cemeter	ry, crer	natory or o	ne of ther plac	re)		Date R_AR	- 1	Location - altin			
	tmen tant:			5 XOther (Sp		nton	nb 🗓	Most											
Dalillino	permit. Pages: Department of I Important: If ite any injury or of		21. Signature of Pt	heral Service L	icensee	_			Ž	Same an	h Addres	Zar Zonk	nin Ling	o Jr	Ba	unera Ito.	al H MD.	ome 2122	4
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¥€.	Physician		Immediate Cause disease or condition		/		CAI	2A. B	ac	A	121	IM	1 T	170	11/	l		Onset and	2 h
ø	/Medical Examiner		resulting in death)			Due to		nsequence	, 1			- 11) A	-11	1 .			`	. ^
	Examiner		Sequentially list co	onditions,	b			th v		o n	17	0 1	1/4	TH	7			YE	111
,	ed sit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate ertying injury		Due to	(or as a co	onsequence)): 	1								VE	411
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, ,	es thi	by F	Part II. Other signi	ficant conditio	ns contri	buting to a	death but no	ot resulting in	n the u	ndertying c	ause giv	en in Part I					,	the cause of	
necords,	equir sen si ould	ted		$\overline{\zeta}$										1	∐ Yes	2[] NO	3 🗌 Pro	obably 4 🗌	Unknown
i i	law las be	Completed	1413	+										24a. W	utopsy		prior to c	topsy findings ompletion of (available cause of
	The cate h	Con													erformed s 22		death? 1 ☐ Yes	2 □ No	
VII.d	iclan sertific sector,	Be	25. Was case referexaminer?		Has	pital:					Oth		of Deat	h (Check or	aly one)				
5	Physical this call direct	1º	1 ☐ Yes 2 ☐ 27. Manper of Dea			28a. Date		2 ER/Ou	tpatier			4 🗀 190		me 5 4 A				cify)	
	ding J. After funer	ion	1 Natural	5 Pending investig			nth, Day Ye		Injury	M	28c. Injur Worl	k? Yes 2 □		Zou. Descri	De now	injury occur	i eu		
VISION	death death ctor: y the	ical	2 ☐ Accident 3 ☐ Suicide	6 Could n	ot be	28e. Plac	e of injury -	- At home, fa	ırm, str								ber or Ru	ral Route Nur	nber,
2	ital or / rs after al Dire led in b	Certification:	4 Homicide			build	ding, etc. (S	Specify)							Town, S				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunat-transit	Medical	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medical E		r: On the		amination ar											(s)
	To the within To the COMP	Me	29b. Signature and		. 0					290	c. Licens	e number	,)		29d	Date signe	ed (Month	Day, Year)	
				Helper							-	~ P	7	·		1201	22		
	10		30. Name and add	ress of person v	who comp	Pleted cau	se of death	(Item 23a)	(Type,	Print)	Li	NTI	50	UM	2	OR	2	090	2
	Sta	ate	31. Date filed (Moi	nth, Day, Year)		32.	a egistrar's	Signature		,		. , , ,		/	. ,		W-1		
ı	Registi	rar		JUN 2 6	2008	1	men	K	1	whi									
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland		artment rtificate			and M			008	20705
	Physicia	o.m.	1. Decedent's Name (First, Middle, Last	and the same of th						2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic	al	Jacqueline	Foure		45 03.	T	Location	4 Death	6	20	2008	600 p M
	Examin	er	4a. Facility Name (it not institution, give Franklin Woo					Location o				County of Death	ro
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. la	ast birthday)	If Under Months		If Under :		8. Date of Birth (Month, Day)	9. Birthr	place (State or Foreign
L	Director		Usual Residence of Decedent	^{™ 2} 7 87	Yrs.	Wiorkino	Days	TIOG 10		July	17,1	920	Mass.
	/land		10a. State 10b. County	10c. City	, Town or Lo							1	0d. Inside City Limits
	a-fsh iified	ctor	MD Baltimo	ore	Bal	Ltimo	re						1 XYes 2 ☐ No
	s with the	I Director	10e. Street and Number 4100 N. Char	les Street		10f. Zip	Code 212	18		1	10g. Citiz US <i>P</i>	en of What Coul	ntry?
	ams 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	1.	4. Race - Americ Black, White,	
2-003p	J within 72 hours after death with the Maryland plans is then "then" instural, or Itams 23a or 28a-f show then "hettes Exurit et militied at the Medical Exurit et al.	by	1 Never Married 2 Married 3 Moriound 4 Divorced	1 ☐ Yes 2 📆No If Yes, Give Year or Dates:	1	1□Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,	,			nite
ດ	72 hc	eted	15. Decedent's Edi (Specify only highest grad	ucation le completed)	16a. Deced (Give life.	dent's Usua kind of wor	l Occupa	ation Juring most	of worki	ng	16b. Kin	d of Business/In	dustry
1717	within lene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		nemak		,			owr	home	
	Hygothe ent,	BeC	17. Father's Name (First, Middle, Last)							(First, Middle,		Gumame)	
yiana		Tof	Louis Speyer							e Torn			
Mar	9 5 5 5		19a. Informant's Name/Relationship (T							<i>l Route Numbe</i> l'owson		Town, State, Zip 21286	o Code)
ore,	es 1 ar of Hea of Item fitem		20a. Method of Disposition 1 Burial 2 remation 3	20b. PI	ace of Dispo	sition (Nan	ne of	a)	D	ate	20c. Loc	ation - City or To	
Baltimor	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		*4 Donation 5 Other (Specify 21. Signature of Puperal Service License	Ba	yviev	V Cre	emat	ory				timore	
ä	Deparming once.		Valut Tung	(amely)	h	Conr	ell	y Fu	nera	al Home	e of		to. MD 21221
	Physician .		23a. Part1. Enter the disease, or sook of shock, or heart failure. List of your limmediate Cause (Final	fications that caused the leath ne cause on each line. LVNG		er the mod			cardiac o			TASIS	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ		ישרי		, α	, (1 (1	P(L)	(17)	* // 3/3	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consequ	ence of):								
	cate be executed the bysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequ	ence of):								
3/60,	e be e: /sician e buria	Ical E		d									
õ	certificate iding phys	ed	IF FEMALE:		- T								
X Q	ath or u	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pr					2:	3d. Date of deliv- Month	ery Day Year
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oras, r	requires that the de een signad by the a nould be detached t	b	Part II. Other significant conditions co	ntributing to death but not resu	lting in the u	nderlying c	ause give	en in Part I.			es 2		he cause of death?
Ö	> Q 70	ompleted								24a. Was a		24b. Were auto	opsy findings available or of
He	The ate ha	Com								perfor		death?	2 ZHO
Vital	Phyeicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	25		(Check only or			
ō	Phye this ral dii	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o		8c. Injury	4 (1)		ne 5 Resid		Other (Special	(y)
0	Attending I r death. ector: After by the funer	atlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м		<br Yes 2 □					
JIVISION	l or Attendi after death. Director: A I in by the fu	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, sti	reet, factory	, office			28f. Location (S City or Tow		Number or Run	al Route Number,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	(Check only 2 Medical Exam	rsicien: To the best of my know iner: On the basis of examinat									
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier	and manner stated.		290	. License	e number			29d. Date	signed (Month,	Day, Year)
	F S F Ö		Din Pa	rispall 1	1. D.		D4	00	08		6	23/0	8
	10		30. Name and address of person who d		23a) (Type,	Print)	1	C	1 1 1	06 56	2,	BALTI	TURE, MD
	Sta	ite	31. Date filed (Month, Day, Year)	ALL 9105 3 Registrar's Signar	A HA	NFC	.12	20	VA	ri v)	NAI TO TI	
	Registr		JUN 2, 6, 200	10 Richard Di	A STORY	FREE							

State of Maryland / Department of Health and Mental Hygiene 108

20706

		-	For State Registrar	Otate of Mc	aryland / L	Cer	tificate of l	Death	ind ivion	tai i i y	Reg. No	2008	2070	6
××	Physicia	an l	1. Decedent's Name (First, Middle,	.ast) FARMER				· · · · ·	1	Date of De Month	Da		3. Time of Death	
	/Medic	al	JUNE	4b. City, Town, or Location of Death					21 2008 11:15 1 4c. County of Death					
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of FOREST HILL HEALTH & REHABILITATION FOREST HILL						Death			HARFOR		
i	Funeral		5. Social Security Number 6		e (In yrs. last bir	_	If Under 1 Year Months Days		4 Hrs. 8. I	Date of Bird Month, Da	th ly, Year	9 Birl	thplace (State or Foreign ountry) Ohio	gn
ii.	Director		273-07-1149 Usual Residence of Decedent	A	94	110.			00	,-1)-	171-	*	OHIO	
	Maryland f show led at	or	10a. State 10b. County MD Harfo	ord	10c. City, Tow	n or Loc							10d. Inside City Limit	
	r 28a-	Director	10e. Street and Number				10f. Zip Code				10g. C	itizen of What Co	ountry?	
36	th witt 23a o Ist be		3212 Jourdan Ct				21009				US			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Vas Decedent of H i Yes, specify Cuba □ Yes 2∏ No	lispanic Orig an, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No n, etc.))-	14. Race - Ame Black, Whit Specify: Wh	te, etc.	
ည်	72 hor	sted	15. Decedent's (Specify only highest	Education grade completed)	16a	Deced	ent's Usual Occup kind of work done OO NOT use retired	ation during most	of working		16b. I	Kind of Business	/Industry	
21	vithin 7 ne. han "l	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+) T. 1	ilfe. E Lber		d)			S	tate Gov	, 1 †	
2	filed w Hygie other ti	Ö	17. Father's Name (First, Middle, La	est)		LUCI	Lan	18. Mother	's Name (Fi	rst, Middle		n Surname)		
an	ld be lental	To Be	Frank Culp	•				Myra	a Cove	rt				
Maryland 21215-0036	should and Men s marke sumatic	-	19a. Informant's Name/Relationship	(Type. Print)	195	. Mailin	g Address (Street	and Number	r or Rural Ro	oute Numb	er, City	or Town, State,	Zip Code)	
	1 and 2 Health a tem 27 is			(Daughter)			Jourdan			, MD			-T Ot-1-	
Baltimore,	Pages 1 ment of Hi ant: If iter ury or oth	İ	20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 4 ☐ Donation 5 ☐ Other (Special Content of the Content			ew C	sition (Name of natory or other place rematory	06			Ba1	Location - City or	MD	
Balt	permit. Departn Imports any inju		21. Signature of Funeral Service Li	Snow)	In	c. 610 W	. MacI	Phail	Rd Be	≥1 A		-	Lr
September 1	Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	aa	a consequence	of):	er the mode of dying						Approximate Interval Between Onset and Death	
€8760/ / ■	tificate be executed ig physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence									
P.O. Box 68	The law requires that the death certifics the has been signed by the attending phage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal deat		Ectopic pregnanc Other (specify)	у				23d. Date of de Month	l elivery Day Year	
rds, P.	quires that n signed b											contribute to the cause of death? 3 Probably 4 Unknown		
Division or Vital Records,	The lay	Completed by		-1,-,						24a. Was auto perf 1∐ Yes	opsy formed?	death?		ole of
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Library Control			104		of Death C	heck onl	one			-
or/	ys di s	은	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpati	ent 2 ER/O	utpatier Time o	IL JUDON	OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred						
ono	Attending r death. sctor: After by the funer	tion	Natural 5 Pending 2 Accident investiga	(Month, Da		Injury		rk?]Yes 2 🗆 I		. 00001100		,,		
Divisi	I or Atten after deat Director	Certification:	2 Accident 3 Suicide 6 Could not be determined 4 Homicide 6 Could not be building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Town, State)							Rural Route Number,				
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best xaminer: On the basis of and manner s	of examination a	ge, deat and/or in	h occurred at the to	ime, date an opinion, dea	nd place, and ath occurred	I due to the at the time	e cause e, date a	(s) and manner a and place, and di	as stated. ue to the cause(s)	
	To the I within 2.	Me	29b. Signature and title of certifier				29c. Licens				29d. [Date signed (Mor	nth, Day, Year)	
	/		David 5	2			03	229	5		J	Nc, 23	,2008	
	4		30. Name and address of person v										Ţ	
	<i>J</i>	ate	DR. DAVID DUNN — 31. Date filed (Month, Day, Year)	615 W. MAC	PHAIL R	OAD	- BEL A	IR, MD	21014	+				
	રા Regist			2008	rar's Signature	A Comment	West !							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Reg. No. 2 0 0 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** SHARDYONNIE 12:06AM 19 2003 TUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE ATIGROH If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕶 F 29-704340 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Brook 1 Yes 2 □ No Completed by Funeral Director $\mathbb{C}\mathsf{M}$ 10g. Citizen of What Country? man 14. Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗙 No Saltimore, Maryland 21215-0036 Blac 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) College (1-4or 5+) omestic 17_Eather's Name (First, Middle, Last) Be P 19b. Mailing Address (Street and Number of (Aust) Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship Balto 920 Kway lason-Uba 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - 0 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ R
4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA PIRAT 2day) **Physician** JON /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innertal director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 1 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? (Month, Day Year) 1 - Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number W D JUNE 19,2003 60 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEGAYE HU 3001 S HANOVER STREET, MO, 2122

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 6 2008

ORIGINAL

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** GILES 8:25 AM BENTON IUN 23 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/A HARBOR HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 22, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** X M 2 □ F 91 1916 Director 217**-**05**-**1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2 ☐ No Anne Arundel Director Linthicum 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 620 Franklin Avenue 21090 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race · American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Equipment Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Giles Minnie Bush 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Irene Fuller - Sister-in-law 412 KOYAL DEAC 20b. Place of Disposition (Name of cametery, crematory or other place) 412 Royal Beach Rd., Pasadena MD 21122
e of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 6-25-2008 | Brooklyn, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. Skinshire H Funeral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician 3 DAUC /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA 3 DA45 Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 3 DAYS this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit FAILUPE RESPIRATORY Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, HYPERKA LEMA 4 DAYS Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PER | PHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CORONAPY DISTAST ARTERY autopsy performe DISEASE ALZHEIMERS AORTIC SCIEROSIS 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No ^oL To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

H

State Registrar DENCIS TERM
31. Date filed (Month, Day, Year)
30 2 6 2008



OFF ICER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

RESOUCH

JUNE

BALTIMORE

23

2008

21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		Certificate of Death			•	Reg. No. 2008 20709				
			Decedent's Name (First, Middle,		Month			2. Date of De	of Death 3. Time of Death				
	Physicia /Medic		Helen R. Garc	zynski				6-17	-2008		7:18P M		
	Examin		4a. Facility Name (If not institution,			4b	•	Location of Death	1	4c. C	ounty of Death) - 1 + O -	
			9120 Kilbride		2 1 11:2	, , ,) If		ngham If Under 24 Hrs.	9 Date of Pir	th		Salto. Co.	
	Funeral Director		217-05-1995	6. Sex 7. Age 1 M 2 X F	(In yrs. last birti		onths Days	Hours Min.	8. Date of Bir (Month, Da 4-23-19	y, Year) 21	9. Birth Cour	place (State or Foreign ntry) Md.	
	and w	-	Usual Residence of Decedent 10a, State 10b. County		10c. City, Town	or Location	on				1	10d. Inside City Limits	
	laryla F sho ed at	5		+0	Notti	agh an	1					1 □ Yes 2 □ No	
	the N 28a-	Director	Md . Bal.	20.	NOCCI		10f. Zip Code			10g. Citize	en of What Cour	ntry?	
Baltimore, Maryland 21215-0036 nermit. Paces 1 and 2 should be filed within 72 hours after death with the Maryland	3a or		9120 Kilbride	Rd.			21	.236			USA		
	ms 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was	Decedent of H	ispanic Origin? (S ın, Mexican, Puerl	pecify Yes or No)- 14	4. Race - Americ Black, White,		
	d within 72 hours after death with the Marylar piene. Than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	1 □ Never Married 2 Marri 3 □ Widowed 4 □ Divorced	ed 1 ☐ Yes 2 Å N If Yes, Give Year or Dates:	0	1 ☐ Yes 2X No Specify:			o raban, otoly	s	White		
2	72 hc natul dical	eted	15. Decedent (Specify only highes	's Education et grade completed)	16a.	Decedent (Give kind	r's Usual Occup d of work done o	ation during most of wor f)	king	16b. Kind	d of Business/In	dustry	
2	rithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		_	NOT use retired stress	")			Cloth	ino	
2	e filed wall Hygie other the	ਤੇ	8th 17. Father's Name (First, Middle, 1	l ast)		Seams	cress	18. Mother's Nar	ne (First, Middle	, Maiden S			
anc	d be fintal Fed of	Be	Unknown	Luoty				Alexandı	•				
arylan(should be land Mental s marked o		၉	19a. Informant's Name/Relationsh	hip (Type. Print)	19b.	. Mailing A	Address (Street	and Number or Ri	ural Route Numb	er, City or	Town, State, Zij	p Code)	
S 25	and 2 s ealth ar n 27 Is ner trau		Carolyn Szek	alski DTR	. 9	101 8	Santa Ri	ita Rd. N	Nottingh	am, M	id. 2123	36	
ē,	- I = 5		20a. Method of Disposition		20h Place of	Dispositio			Date		ation - City or T		
Ē	Pages nent of I unt: If its ury or o		M Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		Sacred	Hear	rt of Je	esus 6-2	21-2008		Balto.		
ati	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service	Licensee	9	22. N	ame and Addre	ss of Facility	Schimune	k Fur	eral Ho	ome	
<u> </u>	8 3 E 6 6		MA	M			970)5_Belai	r Rd. No	tting	ham, Mo		
П			Interval Between									Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a C O	ngesti	ve 1	NOONT	Tallun					
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of	of):							
		-	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):								-		
1	ited insit	i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	S									
Ĭa	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	as a consequence of):								
68760, J	Physician: The law requires that the death certificate be executed trins certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Medical		d									
	rtifica ng ph as th	Med	IF FEMALE:	-			-				-		
Box	eath cer attendir for use	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 - Fetal death		ctopic pregnanc	y		2:	3d. Date of delive Month	very Day Year	
0	ie deg the al	Physician/I	1 ☐ Yes 2 MNo 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5∐0	ther (specify) _						
<u>α</u>	uires that the de n signed by the a id be detached f	Phy	Part II. Other significant condition	ons contributing to death bu	ıt not resulting ir	n the unde	erlying cause giv	ren in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?	
ds,	signe d be	d by							1 🗆	Yes 2	No 3□ Pro	obably 4 Unknown	
Records,	w requir been si should l	Completed							24a. Wa	s an	24b. Were au	topsy findings available	
æ	he lav e has tge 2 t	ᇤ							l per	opsy formed? 2 No	death?	completion of cause of 2 ☐ No	
ta	ician: Th certificate ector, pag		25. Was case referred to medica					26. Place of De	ath (Check only		1,3100	20.00	
<u> </u>	ysici is cer direc	To Be	examiner? 1 ☐ Yes 2 ☐ 10	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Ou	ıtpatient	3□ DOA Oth	ner: 4 I Nursing	Home 5 Hos	sidence 6	☐Other (Spec	cify)	
0	ding Physician: The n. After this certificate he funeral director, page	L:uc	27. Manner of Death 1 ■ Natural 5 ■ Pendir	28a. Date of Inju (Month, Day		Time of Injury	28c. Inju Wo		28d. Describe	how injury	occurred		
Division or Vital	Attending r death. ector: Afte by the fune	Certification:	2 ☐ Accident investi	gation				Yes 2 □ No	201.1	(0)	111 mb	und Davida Novembra	
Ĭ	l or Atten after death Director:	ij	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								rai rioute Nulliber,		
	Hospital of the hours of Funeral Distriction of the hold of the ho		29a. Certifier 1 Certifyii	ng Physician: To the best	of my knowledge	e, death n	occurred at the t	me, date and place	ce, and due to th	e cause(s)	and manner as	stated.	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical one)	Examiner: On the basis of and manner sta	f examination ar	nd/or inve	stigation, in my	opinion, death occ	curred at the time	e, date and	place, and due	to the cause(s)	
	To the H within 24 To the F complete	Me	29b. Signature and title of certifie				29c. Licen:	se number		29d. Date	e signed (Month	h, Day, Year)	
	F > F 0		Samuel (Jumo m)				D0047040 pkins Bayview Circle, Baltimore,				6/23/08		
•	10		30. Name and address of person	and the same of th	eath (Item 23a)	(Type, Pr	int) •	0. 4 0	> 11.		.0 71	22 V	
	1		31.440.	rso, mg 55	07 stob	KIN	Dayron	urce,	34(T)m	re, n	יא עי	NO F	
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registr	A.S	Solo	week!	-					
	1000101	1	3011 21			8 1							

State of Maryland / Department of Health and Mental Hygiene 2008 20710 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month GIANforte 2629M **Physician** 20 /Medical 4c. County of Death 4b. City, Town, or Location of Death Fapility Name (If not institution, give street and number) Examiner Glen BUVNIE WASH If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 ☐ M 2 🖾 F 78 212-26-6905 1930 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show ral, or Itams 23a or 28a-f show Examiner; sust be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Severn Direct the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8134 Windmill Ct. 21144 United States Funerai Peges 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: "natural", hal Hygiene.
ad other than "nature
event, the Movical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental f Health and Menta Item 27 is marked George C. McDowell Hilda B. Harrison 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharleen Blake/Daughter 1251 Doubleday Dr., Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Peges 1 Department of H Important: If Ite any injury or ot once. 2008 June 25, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. Elkridge, Maryland 4 □ Denation 5 □ Other (Specify) kley-Ruddick Funeral Home, P.A. Crain Hwy., S.E., Glen Burnie, 21. Signatu f Eun ral Se 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition eriosclero-**Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner to the Hospitel or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): O. Box 68760 attending physicien Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year be detached for 5 Other (specify) ☐Yes 2 ☐ No the 9 Unknown 9 Unknown ģ <u>م</u> 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 Unknown 1 🗌 Yes 2 No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 Yes 2 No certificate 1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To after death. Director: After this funeral 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 25 ON 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Andle Registrar JUN 2 6

DHMH 17 Rev 1/2001

		1 - For state Registrar amend #24a&			eruncate of	Death	2. Date of Dea	71111	8 3 2 0 7	
Physic	ian			Caiman			Month	Day Yea		
/Medi		Jack	David	Geiman	4h City Town	or Location of Death	June	18, 2008 4c. County of De	/:25P	
Exami	ner	4a. Facility Name (If not institution, give								
		11227 Red Lion Ro 5. Social Security Number 6. Sec		(In yrs. last birth		Marsh If Under 24 Hrs.	8. Date of Birt		Baltimore 9. Birthplace (State or Fore	
Funeral Director		219-40-7453	M 2□F 64		rs. Months Days	Hours Min.	8. Date of Birt (Month, Da Sept. 1		Country) aryland	
rryland show	_								10d. Inside City Lim	
e Ma	Director	Maryland Balti	more		White	Marsh			1 □ Yes 24(3X)	
or 2	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What 0	Country?	
23a	<u>ra</u>	11227 Red Lion F	oad			21162		United S	tates	
ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene." If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ihu Madical Examirer must be notified at	by Funeral	1 ☐ Never Married 2 ☑ Married	12. Was Decedent Event Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		13. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No	oan, Mexican, Puerto	pecify Yes or No- Pican, etc.)	- 14. Race - Ar Black, Wr Specify:	merican Indian, nite, etc. White	
thin 72 hours aft ie. ian "natural", or Medical Exami	eted b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu (Specify only highest grade	Year or Dates:	16a. [Decedent's Usual Occu	pation	ina	16b. Kind of Busines		
vithin 7	Completed	Elementary/Secondary (0-12)	(0-12) College (1-4or 5+) life. DO NOT use retired)					Dve Shop		
led v Hygie her t		11 Years			Dye Maker	40 Mathada Nam	- (First Middle			
be find he de ot	Be	17. Father's Name (First, Middle, Last)	G - 1			1	aret Da	Maiden Surname)		
should be tnd Mental s marked o	은	David Venzke				_				
and 2 shuealth and n 27 is m		19a. Informant's Name/Relationship (Type. Print) Mrs. Mary Geiman (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 11227 Red Lion Road White Marsh, Marylo								
of He fitem		20a. Method of Disposition 1 ☐ Burial 2 🔄 Cremation 3 ☐ R		20b. Place of D	Disposition (Name of crematory or other pla	ice)	Date	20c. Location - City	or Town, State	
Pages nent of int: If its iry or o	١.	Donation 5 Other (Specify)	emoval from State	Hillto	p Service	Corp. 6/2	4/2008	Towson,	Maryland	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		21. Sign ure of Funeral Service Livensee 22. Name and Address of Facility Louda-Ruck Funeral Home of Dundalk, Inc.								
		23a. Part 1 Enter the disease, or compli	cations that caused th	e death Do no					21222 Approximate	
		snock, or heart failure. List only or	ne cause on each line.				o. 100p. a.o.) a.		Interval Between Onset and Death	
Physician		disease or condition disease (Annual Day of Canal Day of								
/Medical Examiner		Due to (or as a our sequence of):								
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
Sit vie	Examiner	cause Enter Underlyin Cause (Disease or injury								
and	хап	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):								
be executions and ician and burial-tran	<u>=</u>	resulting in death) Last Due to (or as a consequence of):								
ficate be executed physician and s the burial-transit	edical									
The law requires that the death certificate ate has been signed by the attending physionage 2 should be detached for use as the I	/Mec	IF FEMALE:	0. 16							
ath c	ian/	23b. Was decedent pregnant in the past 12 months?	onths? 1 Live birth 2 Li-etal death 3 Letopic pregnancy Mor						delivery Day Year	
the a	sic	1 □Yes 2 □No 9 □ Unknown	4 ∐ Pregnant at ti 9 ☐ Unknown	me of death	5 Other (specify)				, , , , , , , , , , , , , , , , , , ,	
w requires that the death certifi been signed by the attending should be detached for use as	Physician/M		substitution to double but a	nat requiting in t	ha undarkina asusa si	ven in Deut I	220 Did to	phaga usa contributa	to the cause of death	
res th	Completed by F	Part II. Other significant conditions cor	imbuting to death but i	not resulting in t	ne underlying cause gi	veri iii Fait i.				
equii		COID					المراا	res 2 No 3	Probably 4 Unkno	
as b		CAD					24a. Was	an 24b. Were	autopsy findings availa to completion of cause	
The ate h							perfo		es XXNo	
Physician: this certific ral director, p	Be C	25. Was case referred to medical				26. Place of Deat				
ysic is ce direc		examiner? 1 ☐ Yes 2 ☑ No	iospital:	2 ER/Out	eatient 3 DOA Ot	her: 4 Nursing He	ome 5 Resid	dence 6 □Other (S	pecify)	
g Ph erth eral	Ë	27. Mannar of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								
ndin Hr.: efun	엹	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, \	rear) III		Yes 2 □No				
Attending r death. sctor: After by the funes	Ę	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number						Street and Number or	Rural Route Number,	
after Dire	Certification: To	4 ☐ Homicide determined	building, etc.	(Specity)			City or Tov	vn, State)		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical C			xamination and	death occurred at the for investigation, in my					
the thin the	Mec	29b. Signature and title of certifier	and manner state	u.	29c Licen	se number		29d. Date signed (Mo	onth Day Year)	
or viti		200. Signature and title of Certifier	Co Van	110	29C. Licen	(3 11 —	,	_	_	
11 -		Jun NI.	sees.	MID	100	>116		June 1	1, 2006	
4		30 N m and address of person who co	mpleted cause of dea	th (Item 23a) (T	ype, Print)	Contor <	+ 0a.1	IL Rail	9, 2008	
C+.	ate	31. Date filed (Month, Day, Year)	32/ Registrar's	s Signature	read of		1 100	J F 041	NIOCITE	
			_	2.0	25 p.B					

an Goodwyn	State of Maryland / Department of Health 1- For State Certificate of Death		/giene Reg. No	200	18 2071				
Physician/ edical Examiner			2. Date of Death Month Day June 20, 2008	Year	3. Time of Death 0351 hrs				
		wn, or Location of Death		c. County of Death	IA-				
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 216-25-8139 1 M 2 F 24 Yrs.			Foreign					
Maryland 28a-f show any d at once. ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Baltimore			10d. Inside City Limits 1 Yes 2 No				
tifie a			10g. Ci	tizen of What Coun	try? can Indian, Black,				
s after death with ral", or items 23 niner must be no by Funeral	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	Cuban, Mexican, Puerto No specify:		White, etc. Specify: Bla	uck				
5-0036 ed within 72 hours after stygiene. other than "natural", the Medical Examiner Completed by		ccupation (Give kind of w ng life. DO NOT use retir Uder ±		Kind of Business/II	ndustry				
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 ment of Health and Mental Hygiene fant: If item 27 is marked other than or other traumatic event, the Medical To Be Comple	Brian Goodwyn	18.Mother's Name		hews	Tie Oods)				
	Verence Matthews-Oliver-nother 1224 W 20a. Menod of Disposition (Name	. Lafaye	tte Ave.	Baltin Location - City or	ore, Mai				
Baltimore, MD 21215-C permit. Pages I and 2 should be filled v Department of Health and Mental Hygi Important: If Item 27 is marked oth injury or other traumatic event, tat- To Be Co	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and A	ial Park 6 ddress of Facility Park	-25-08 K	Pardallsto	wn Marylan				
Physician /Medical *xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line. Immediate Cause (Final disease a, Multiple Gunshot Wounds	dying, such as cardiac or	BaHimor respiratory arrest, sh	hock, or head	proximate i terval Between Onset and Death				
)	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.								
scuted and transit al Examine	C. Due to (or as a consequence of):								
50, te be execut ysician and burial - tra	UNPENDED AMENDED			2d Data of deliver					
DIVISION Of VITAL RECORDS, P.O. BOX 68/6U, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical Es	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Special Special	3 Ectopic pregna		3d. Date of delivery Month D	Day Year				
ires that the case of the detached by the detached by Physical By		ause given in Part I.		✔ No 3 Prob	the cause of death?				
UNISION OF VITAL RECORDS, tal or Attending Physician: The law require ran Brace dearh. at Director. After this certificate has been sig led in by the funeral director, page 2 should be artification: To Be Completed		·····	24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of es 2 No				
r Vital Rec Physician: The I ar this certificate I ral director, page To Be Corr	25. Was case referred to medical examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DC	A Other Nursin	4 Nutsing Fighter 5 Residence 6 Other.						
DIVISION OF Spital or Attending Phenous after death. Increal Director: After the filled in by the funeral Certification: T		1 Yes 2 V No	28d. Describe how in Subject shot		Doub Number City				
DIVISION DIVISION To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the edical Certificati		4 Homicide determined (Specify) Local Street 500 Block of Bloom Street, Baltimore, MD							
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my one and manner stated. 29b. Signature and title of certifier 29c.		t the time, date and p		e cause(s)				
	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	Ju	ne 20, 2008					
8	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltim 31. Date filed (Month, Day, Year) 32. Segistrar's Signature 32. Segistrar's Signature 33. Date filed (Month, Day, Year)	ore, MD 21201		· · · · · · · · · · · · · · · · · · ·					

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 20713 2. Date of Death 1. Decedent's Name (First, Middle, Last) HARDIN **Physician** 1135AM WORMLEY THELMA 2008 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) FEB 6 1916 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex **Funeral** New Jersey 1 □ M 2 💢 F 186-12-8928 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Elkridge MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6438 Koffel Court 21075 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No altimore, Maryland 21215-0036 Specify **Black** \$ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Public Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nalle Finetta Wormley Roscoe С. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trau once. 6438 Koffel Court, Elkridge, MD 21075 Marilyn Hardin - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 6/25/2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee H. Williams 22. Name and Address of Facility of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTIONS **Physician** /Medical Due to (or as a consequence of): DAYS **Examiner** CONGESTIVE HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner PNEUMONIA DAYS BACTEREMIA WITH Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, UNKNOWN ACUTE RENAL Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown ed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ATRIAL FIBRILLATION 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has l irector, page 2 s autopsy death? 2 17 No director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation in 24 hours after control the Funeral Director: Af 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 ivertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0

State

30. Name and Iddr

31. Date filed (Month, Day, Year)

PETA-GAY

PHYSICIAN

32 Registrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

JINCKSON BOOTH

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Registrar

OCME

Laron Locke MD.

31. Date filed (Month, Day, Year)

HUN

10. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 24, 2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6-19-2008 Day **Physician** 8:45A Shirley M. Hammen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. Co. Perry Hall Apt. 303 15 Juliet Lane If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Md. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F 78 218-26-3199 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Perry Hall Balto. Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or Items 23a or 21 any injury or other traumatic event, the Medical Examination once. USA 21236 15 Juliet Lane Apt. 303 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 10th Executive Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ု Helen Winfelder Sam Foracappo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 303 15 Juliet Lane Husband Albert Hammen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 MBurial 2 □ Cremation 3 □ Removal from State 6-23-2008 Balto. Co. St. Joseph Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 21236 9705 Belair Rd. Nottingham, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Fina! Physician year resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 21 No 3 ☐ Probably 4 ☐ Unknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2∏No 1 TYes 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural (Month, Day Year) 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

DOD 6/19/08 Hammen

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number

29b. Signature and title of centifier

29d. Date signed (Mgnth, Day, Year)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death nt's Name (First, Middle, Last, 23, 2008 **Physician** June 5:05AM axanna /Medical acility Name (If not institution, give street and number) Baltimore 4b. City_Town, or Location of Death Examiner lowson Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth 9. Month, Day, **Funeral** Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examiner must be neitlied at once. 1 ☐ Yes 2 No **Funeral Director** wings + more 10g. Citizen of What Country? 10e. Street and Num USF Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Tyes 2 No δ 3 MWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Conge (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be lark ပ a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Columbia, MD 21044 10258 Rutland Round Rd. Hunt-Bonitto 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State thod of Disposition Date 1 Burial 2 Cremation 3 Removal from State 28.08 4 Donation 5 Dother (Specify) of Funeral Service Licenses 5151 Bulto. Nat 1 Pilce (21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myelofenons Leokema **Physician** month ALUITE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Myclodys plashic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 DNo Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Breast concer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No certificate 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSpice 1 Yes 2 VNo 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

JUN 2 6 2008 Registrar

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31. Date filed (Month, Day, Year)

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CUTARIES 32. Registrar's Signature

ST TONSON MD 21204

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Deceden Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical City, Town, or Location of Death not institution, give street and number) County of Death Examiner Birthplace (State or Foreign Country) Date of Birth (Month, Day, Age (In yrs. last birthday) **Funeral** Hours Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified <u>at</u> 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If Item 27 is marked other the any Injury or other traumair. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, 118 Kannel 20b. Place of Disposition (Na cemetery, crematory or Method of Disposition Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Nodlawn 21. Signature of Funeral Service License and Address of Facility aus Balto, MID 21224 Mere National 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Malignant /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy perform To the Funeral Director: After this certificate To the Hospital or Attending Physician: ector. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes Hospital: Other: 200 P 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 23/28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Main 2436 Miller Russissan SMUT 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State JUN 2 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 | | | | | | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** S. 23, 2008 June 9:15 A M Margaret Hoover /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FutureCare North Point Baltimore Co. Dundalk If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1□M 21 F Director 217-12-5737 86 May 14,1922 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at XXYes 2 □ No Director Marvland N/A Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a 3404 Dillon Street 21224 United States
14. Race - American Inc.
Black, White, etc. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumath. 12 Years Secretary Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John H. Hoover 2 Margaret C. Lang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan E. Kelly (Sister) 618 48th Street Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 6/27/2008 Baltimore, Maryland 22. Name and Address of Facility 21. Sign sure of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner be executed Box 6876020 and Due to (or as a consequence of) attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🕱 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tyes 2 No 3 robably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 : autopsy Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA 1 Inpatient P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier i 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onl) one) 29b. Signature and title of certified 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year)

2008

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/Medic Examin		4a. Facility Name (I			umber)			4b. City, Town, o	or Location of Death			. County o			
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar mast by matified at once.	∄	11. Marital Status 1 □ Never Marr	ied 2 🔀 Mar	12. Was De Armed F ried 1 🕱 Yes If Yes, 0	Forces?		. 13	3. Was Decedent of I If Yes, specify Cub 1 □ Yes 2 2 No		pecify Yes or No Rican, etc.)	0-		- Americ , White, 6	an Indian, etc.	
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permit. Departi		21. Signature of Fu	uneral Service	Licensee	-			22. Name and Addr Duda-Ruc	ss of Facility Funeral	Home of	f Du	ndalk	i, Ir	nc.	
		23a. rrt 1. Enter t	the disease, o	r emplications that	caused	the death.	Do not e	7922 Wise		indalk, or respiratory		yrand	21	222 Approxima Interval Be	ite
Physician /Medical	5 }	Immediate Cause disease or condition resulting in death)	(Final	a. Ac	ul	en	Mo	cardial	TM	faro	h	04		Onset and	Death
Examiner				Due to	the	a conseque	ence pr):	enc c	oronam	Vasi	ula	r du	Sear	l	
ist wide	Examiner	Sequentially list co if any, leading to im cause. Enter Unde Cause (Disease or	nditions, nmediate erlying	Due to	o (or as	a conseque	ence of):		U						
e executec		that initiated events resulting in death)	S	c	o (or as	a conseque	ence of):								
ificate be executed a physician and stransit is the burial-transit	dical			d											
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2	months?	4 □ Pre	e birth egnant at	of pregnan 2 Fetal of t time of de	death 3	B Ctopic pregnan	су			23d. Date Mor		ery Day	Year
nat the d by th	Phys	9 ☐ Unknown	1	9 Uni		ut not rosult	ting in the	underlying cause gi	von in Part I	23e Did	tobacco	use contri	bute to th	ne cause of	death?
equires the sear signer ould be d	ted by	_ Obs	struc	tive s	3/6	ep_		TPries	,		Yes 2	/		ably 4	
The law rate has be	Completed	Sa	rcoic	10815.		¥				24a. Was auto perfi 1 Yes		- d	rior to co eath?	psy findings mpletion of 2 No	available cause of
sician: certific rector,	Be	25. Was case refer examiner?		Hospital:				Ot	26. Place of Dea	. 1					
g Physical this seral di	n: To	1 ☐ Yes 2 27. Manner of Deat	th	28a. Dat	Inpatie		R/Outpat 28b. Time Injun	of 28c. Inju	4 LI Nursing F	28d. Describe		6 Othe		<u>y)</u>	
tendin leath. tor: Afi the fur	catio	1 Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pendii invest 6 ☐ Could	igation				M 1 [Yes 2 □No	204	(0)	7.81		1.5- 1-11	
al or Al	Certification:	4 ☐ Homicide	deterr	ninod 200, Plat	lding, etc	c, (Specify)	ne, tarm, :	street, factory, office		28f. Location City or To			er or Hure	i rioute ivui	mber,
e Hospita 24 hours e Funera etely fille	Medical C	29a. Certifier (Check only one)		Examiner: On the		f examinati		eath occurred at the investigation, in my							(s)
To th Withir To th comp	Me	29b. Signature and	title of certifie	er	17 11	011.	m	29c. Licen	se number	94	29d. D	21 00	I.	Day, Year)	
10		30. Name and add	ress of persor	who completed ca	use of d	eath (Item	23a) (Typ	e, Print) 301	ST. BO	altima	325	COLI) (श्रीवर	12
Sta Registra		31. Date filed (Mon	oth, Day, Year,		Registra	ar's Signatu	ure 473	w		11111					
				7	_	1	- 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First Middle Last) 2. Date of Death Physician June ^{Day} 2008 Year John W. Kirckhoff Jr. 22 9:05p M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. S**9119**ecurity Number -216-09-1794 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Sept. 26, 1916 **Funeral** 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Hours Months Days 1 1 ★M 2 □ F 91 Director MD Usual Residence of Decedent with the Maryland 10h County 10a State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Evaniner must be notified at Director Md Baltimore Freeland 1 ☐ Yes 2 ☐ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 1211 Freeland Road 21053 Funeral USA Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23: 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No ò White Specify: 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Martin Marietta 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Kirckhoff Sr. Minnie Ault ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Kirckhoff /wife 1211 Freeland Road Baltimore MD 21053 permit. Pages 1 and Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 6/26/08 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Survi 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or co shock, or heart failure. List on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 484RS Physician 15CHEMIC CARDIOMYOPATHY disease or conditior resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a con equence of) death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the use as attending IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Year 5 Other (specify) the ☐Yes 2☐No detached 9 Unknown þ The law requires that signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by DASTROINTESTINAL BLEEDINI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen ATRIAL PIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 2 EMPHY SEMA After this certificate funeral director, pag 25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo 1 ☐ Yes 2 No or Attending Physician: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) #05/1CE 1 Yes 2 X No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D104395 JUNE 23. 2008

Registrar

State

6565 NCHAPLES ST, 8WIE 209

BALTIMORE, MO 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Resistrar's Signature

DANIEUE DOBERMAN, MO

6

31. Date filed (Month, Pay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04839 State of Maryland / Department of Health and Mental Hygiene Ronald Marion Kuta 2008 20721 Certificate of Death Reg. No. 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 23, 2008 Year 1755 hrs Examiner Ronald Marion 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Bel Air 1601 Martha Court #403 If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Foreign Maryland **Funeral** Months Hours Feb17,1952 Director 56 214-50-5203 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 1 Yes 2 No or items 23a or 28a-f show must be notified at once. Bel Air Harford Md. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

[ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country 10f. Zip Code 10e, Street and Number U.S.A. 21015 Unit 403 1601 Martha Court 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 1 X Yes White Specify: Divorced If Yes, Give Year 1 Yes 2 No specify: ğ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Bayview Completed College (1-4 or 5+) Elementary/Secondary (0-12) Medical Center 21215-0036 egistered Nurse 18.Mother's Name (First, Middle, Maiden Surname) (UNK) 17. Father's Name (First, Middle, Last) Be Ann Marion Kuta

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 BelAir.Md21015 Baltimore, MD Martha Court Unit <u>Margaret Kuta</u> 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 6-27-08 Cem. Holy Rosary permit. Pages
Department o
Important: 4 Donation 5 Other Specify: 22. Name and Address of Facility aczorowski Funeral Home, PA 21. Signature of Funeral Service Licen ee Dundalk Ave. Baltimore 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and hysician failure. List only one cause on each line Death a. Atherosclerotic Cardiovascular Disease **ladical** Immediate Cause (Final disease .xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

	events resulting in death) Last Due to (or as a consequence of):	
	d	
2	UNPENDED AMENDED	
Sicialities	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
2 7 7	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcoholism	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
mpiered		24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
3	25. Was case referred to medical 26.Place of Death (Check on	ly one)
å	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other 4 Nursing	Home 5 Residence 6 ✔ Other: Scene
10n: 10	28a. Date of myy 2bb. Time of mysty	8d. Describe how injury occurred
ertification	Homicide	28f. Location (Street and Number or Rural Route Number, City or Town, State)
sa C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and do (Check only one). Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the control o	lue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 24, 2008

1.x1

31. Date filed (Month, Day, Year) 1008

Signature and title of certifier

Laron Locke MD.

29b

State

Registrar

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

181130

and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10xc Per FH G880 6/26/08 Ib Certificate of Death

State of Maryland / Department of Health and Mental Hygiene
Reg. No.

Reg. No. 2008 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2/1 **Physician** /Medical 4c. County of Death tion, give street and number, Examiner Date of Birth (Month, Day, Year) - 9 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. |ast_birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🕱 F Marylano Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if the Jical Evanination must be muffled at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Gwynn Oak 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number HIMORE Str Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married and 21215-0036 1 □Yes 2 No Specify: Specify. ξ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ٥ Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Paral Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 20a. Method Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 2/Name and Address of Facility augment Services (Augment Havene Funeral Services, Md. 21229) 15/ Baltimure National Pike Palto., Md. 21229 21. Signature of Funeral Service Licensee aus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Asthonations Status **Physician** 40 minutes /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the irector, page 2 s autonsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\Bigcap \) Nursing Home \(5 \) \(\Bigcap \) Residence \(6 \) Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lune 22, 2008 MD BL 9916795 30. Name and address of person while completed cause of death (Item 23a) (Type, Print) 21227 Balkimore, may land mighan Chickley 900 South Catur Avenue

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 6 2008

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** MARIE E LIND 06 A M 1:01 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE, MD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 17, 1933 7. Age (In yrs. last birthday)
75 Yrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 126-26-2125 1 □ M 2 ☑ F Pennsylvania Director Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Chase 1 ☐ Yes 21 No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or Cypress Lane "natural", or items 23a 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 3☐ Married 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White Completed by 3 □ Widowed 4 □ Divorced Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Production Worker Automatic Rolls 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be ealth and Mental Rose Vecchio Rocco Savini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Lind Sr./ Husband 7 Cypress Lane Chase Maryland Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 6/23/08 Towson Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck 5305 Harford Road Inc. Baltimore Maryland hustend Welton 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner CARCINOMA METASTATIC BREAST Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of Examiner certificate be executed HEPATIC FAILURE physician and s the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9∏Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ END RENAL STAGE DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown Completed CORONARY 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ARTERY DISEASE 24a. Was an s certificate has b lirector, page 2 s' performed Division or Vital 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After I completely filled in by the funera Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P20698 06/21/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) 2 6 2008

ARATI

KARHADKAR



Ó

BLVD

BALTIMORE,

State of Maryland / Department of Health and Mental Hygiene 2008 20724 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year 6:30PM M Earl U. Marsh, Jr. 6-23-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Balto. Co. 5. Social Security Number 6. Sex X□ M 2□ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 229-18-4283 8-23-1922 Director 85 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at agree. Balto.Co. Md. Director Nottingham 1 ☐ Yes 2 T No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4008 Kahlston Rd. 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Typesetter Printing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl U, Marsh, Sr. Jennie Pearson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leola A. Marsh Wife 4008 Kahlston Rd. Nottingham, Md. 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6-27-2008 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Zion U.M. Cemetery Churchville, Harford Co. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home K 9705 Belair Rd. Nottingham , Md. 21236 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PROSTATE CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To HOSPICE 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Hospital 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the I within 2. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D43721 2560% 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) JUN 2 6 2008 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** AN 2008 UNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA DITALOF ALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
MARYLAND If Under 1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year Months Hours 1**⊠**M 2□ F Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Partical Exprisions, ust be putilized at 1X Yes 2 ☐ No Director YARVLAND 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 15A Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify. \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Elementary/Secondary (0-12) College (1-4or 5+) SELF-EMPLOVEN OTHGRADE 18. Mother's Name (First, Middle, Maiden Surname) and 17. Father's Name (First, Middle, Last) Be (should be ANUEL ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7 Baltimore, Important: If item any Injury or othe Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ţ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of 21. Signature of Funeral Service Licensee TK. FUNERAL HOME leams Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trar Physician/Medical the for use as IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 2 No 2 No Vital 1 X Yes Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 🗌 No 2 ☑ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To of this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending Division 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No death. 2 Accident within 24 hours after deat To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier < 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 413 commun conforsville 410 Year) 6 2008

DHMH 17 Rev 1/2001

State Registrar Day.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per Phy G880 6/26/08 III and Mental Hygiene Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:53AM Moore 70m 22 2008 /Medical Pacility Name (If not institution, ge street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Gene If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 7.15. Birthplace (State or Foreign Country) last birthday 6. Sex **Funeral** Min. 1 □ M 2 👿 F Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Operatment of Heath and Mental Hygient reatural", or items 23a or 28a-f show Important: I filem 27 is marked other than "ratural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at **Funeral Director** toward 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8950 2079 Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than ' /Secondary (0-12) College (1-4or 5+) Elementary lications Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship MD 20794 Jessup. arrol Date 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other p 20c. Location 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ElKridge, 21. Signatur of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** te myocand /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Day Month Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, <u>ک</u> 1 Nes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? After this certificate 2 No 1 Tes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA sidence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signate and title of certifie 29c. License number June 22, 2008 completed cause of death (Item 23a) (Type, Print) 1105 TLITTLE Patopout Pkuy # 210 JACKINIMI olumbia 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Year)

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Audrey Mikolaichik June 21 2008 7:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1753 Stokesley Road Dundalk 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 F Director 212-30-4303 Dec. 29,1934 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a, State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examinaria ust be retiffed at 10d. Inside City Limits Director Dundalk 1 ☐ Yes 2KXNo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 1753 Stokesley Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TXNo Specify: ð Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen V. Leitch Franklin Rhodes ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Basil Mikolaichik (Husband) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr 1753 Stokesley Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Park Cem. 6/25/2008 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Idarbuk tau 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** noumons disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami cor C Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) the 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate performed? 1 □ Yes 2 □ No 2 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) - on - low 031865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimoro 20 21201 6 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 26 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 20728 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2028 lune ERNEST MERMELSTEIN 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sinai Hospital of Baltimore Baltimore Ut If Under 1 Year | If Under 24 Ars. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpia PA **Funeral** Min. 06/08/1934 Months Days Hours 1 X M 2 □ F 141-26-6997 74 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wolfral Event, increase to reather any once. 10a. State 1 Yes 2 No Director BROWARD DEERFIELD BEACH FL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 202 RICHMOND A 33442 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 WHITE 1 □ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER DRIVING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERMAN MERMELSTEIN PEARL GREENWALD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SIMY LEWIS / DAUGHTER 6515 GARDENWICK ROAD, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERSIDE CEMETERY 06/22/2008 LODI, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. Matt (evinso-8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypercaphic respiratory faulure **Physician** days /Medical Due to (or as a consequence of): Examiner 20 years Chronic obstructive tulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760; the attending physician Physician/Medical as the for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No should be detached if 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, shotructive sleep annea 1 Yes 2 No 3 Probably 4 Unknown Completed has been morbid obesit 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2☐No 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate wordinary anten disease 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA ည 27. Man of Death 28a. Date of Injury (Month, Day, Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number June 21, 2008 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chelsea C Pinnix MD, PND Since Hospital of Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Ernesi Mermelstein

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Stepend #5 Per FH G881 7/01/08 JH Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 June 24 2:55 p M Nelson Joseph 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physician

Funeral

/Medical

Kar1

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division or Vital Records, P.O. Box 68760,

i.						4b. City, Town, o			40				
	262 Oak					Severn				Anne Ar	undel		
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	Usual Residence of	Decedent 10b. County		10c City	, Town or Lo	cation					10d. Inside City Lie		
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rect	10e. Street and Nu		under	, D	everna	10f. Zip Code			10g. C	itizen of What Co	ountry?		
	262 Oak (Court				2114	ó		Ü	USA	·		
Funeral Director	11. Marital Status	ied 2 Married	12. Was Decede Armed Force 1 \(\text{Yes} \) 2[nt Ever in U.S \$? XNo		**	ispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.				
by	3 Widowed		If Yes, Give Year or Date			∐Yes 2ZANo	Specify:		Specify: White				
Completed	(Spec	15. Decedent's Ed			(Give	lent's Usual Occup kind of work done	during most of workin	g	16b. l	Kind of Business	Industry (Industry		
dmo	Elementary/Seco	ndary (0-12)	College (1-4d	or 5+)	Attor	00 NOT use retire: ney	1)			Law			
ပ္ပို့	17. Father's Name	(First, Middle, Last)				18. Mother's Name	(First, Middle	, Maide				
To Be	Charles	Gordon	Nelson	n, Jr.		Frances Mae Orth							
	19a. Informant's N	ame/Relationship (Type. Print)		19b. Mailin	Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
	Lexi Ne	lson - wi	.fe				Severna		21146				
	20a. Method of Disp		Removal from Sta			sition (Name of natory or other place	Town, State						
		5 ☐ Other (Specif	• •	Met		cematory, Inc. 6/25/2008 Baltimore, MD							
	21. Signature of Fu	Steven	Nilli	ams		²² Chame and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228							
	23a. Part1. Enter t	he disease, or com	plications that caus	ed the death						ce, MD_	21228 Approximate		
	shock, or hea		one cause on each	line.	mol	анома	ig, such as cardiac oi				Interval Betwee Onset and Deat		
	disease or condition resulting in death)	n 🕜	a Due to (or a	as a consequ		21101010					14v. 4m		
ner	Sequentially list conditions, if any, leading to immediate the business and the sequence of th												
Examiner	Cause (Usease of Injury that initiated events c.												
	regulting in death)	ant .	C										
=	resulting in death)	_ast	Due to (or a	as a consequ	ience of):								
dical	resulting in death)	ast	Due to (or a	as a consequ	ence of):								
ysician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 [t pregnant months?	Due to (or and a discourse of the control of the co	ne pf pregnal 2 □ Fetal at time of de	ncy death 3	Ectopic pregnance	,		I	23d. Date of del Month			
	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2[t pregnant months?	23c. If yes, outcor 1 □Live birth 4 □ Pregnant 9 □ Unknowr	ne pf pregna 2	ncy death 3 eath 5	Other (specify)		23e. Did	tobacco	Month	Day Year		
by	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2[9 □ Unknown	t pregnant months?	23c. If yes, outcor 1 □Live birth 4 □ Pregnant 9 □ Unknowr	ne pf pregna 2	ncy death 3 eath 5	Other (specify)			tobacco Yes 2	Month use contribute to			
by	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2[9 □ Unknown	t pregnant months?	23c. If yes, outcor 1 □Live birth 4 □ Pregnant 9 □ Unknowr	ne pf pregna 2	ncy death 3 eath 5	Other (specify)		1 🗆 24a. Was	Yes 2	Month use contribute to 2☑No 3☐Pr 24b. Were au	Day Year the cause of death robably 4 Unkr		
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e Completed by	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 [9 □ Unknown Part II. Other signi	t pregnant months?	23c. If yes, outcor 1 □Live birth 4 □ Pregnant 9 □ Unknowr	ne pf pregna 2	ncy death 3 eath 5	Other (specify)		24a. Was auto perfi	Yes 2 an psy prmed? 2 3 N	Month use contribute to 2 ☑ No 3 ☐ Pri 24b. Were at prior to death?	Day Year the cause of death robably 4 Unkr utopsy findings avai completion of cause		
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o Be Completed by	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown Part II. Other signi	t pregnant months? No red to medical No h 5 Pending investigation 6 Could not b determined	23c. If yes, outcor 1	ne pf pregnal 2 Fetal at time of de a but not resu titient 2 E njury Day Year) injury - At hotel. (Specify st of my knows of examinat	ncy death 3 = seath 5 = se	t 3 DOA Oth 28c. Injur M 1 Det, factory, office	en in Part I. 26. Place of Death er: 4 □ Nursing Hor y at k? Yes 2 □ No	24a. Was auto perfi 1 Yes (Check only me 5 Ares 8d. Describe 8f. Location (City or To	yes 2 an psy prmed? 2 one) idence how inju	Month use contribute to 2 \(\text{No} \) 3 \(\text{Pr} \) 24b. Were at prior to death? 1 \(\text{Yes} \) 6 \(\text{Other} \) (Spectral Course death) and Number or References and Number or References and manner as	Day Year to the cause of death robably 4 Unkr utopsy findings avai completion of cause 2 No cify) ural Route Number,		

State Registrar

31. Date filed (Month, Day, Year)
JUN 2 6 2008

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William V. Pearce ino /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis = Loch Raven Center Towson Baltimore 8. Date of Birth (Month, Day, Year)
May 25,1922 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 215-18-5343 1 SM 2 □ F 86 MD Director Usual Residence of Decedent 10c. City, Town or Location 0d. Inside City Limits r 28a-f show notified at 10a. State 1 ∐Yes 2√2 No MD Baltimore Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or the Medical Examiner must be 9115 Lamaze Road 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 N Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic than " Elementary/Secondary (0-12) College (1-4or 5+) Auto 11th 1 and 2 should be filed Health and Mental Hygi is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William K. Pearce Rhoda Vincent ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 is
any injury or other trau Sharon Talley /daughter 9115 Lamaze Road Baltimore MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 6/25/08 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto. 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part. Enter the disease, or company shock, or heart failure. List only Immediate Cause (Final ummas **Physician** disease or condition resulting in death) /Medical Due to (or as a * nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1□Yes 2□No the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖄 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has autopsy performed: certificate 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and fine of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

0 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2/204

6 2008

amend item 11 per inf 2881 7-8-08 vt State of Maryland / Department of Health and Mental Hygiene amend #20a c&22 Per FH G881 7/1/1/208 JF Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 16, EZIZIB Month JUNE **Physician** 1:22 AM Walter Preller /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 M 2□ F Maryland 212-28-0587 77 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Ever invir riust be notified at Director 1 □Yes 2 □ No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Virginia Avenue #701 21286 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No Specify: þ Specify: white **3** Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) transportation permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygienn Important: If Item 27 is marked other than any Injury or other traumatic event, The gones. cab driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Agnes Watson Henry Preller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Virginia Avenue #701 Baltimore, MD Mary Kissel/executor 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 ☐ Removal from State Hilltop Service Corp. 6/30/08 Towson, MD 4□Donation 5\ Other (Specify) in/state 22. Name and Address of Facility Leon 3r Director 21214 5305 Harford Road 21201 Baltimore, MD Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fallure. List only one cause on each line. 23a. Part 1 shock Approximate Interval Between Onset and Death Immediate Ouse (Final **Physician** disease or condition resulting in death) MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner SEPTIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of). I or Attending Physician: The law requires that the death certificate be executed after death. physician and the burial-transit BOWEL <u>INFARCTION</u> resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 ☐ Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2 29b. Signature and title of certif 29c. License number 29d. Date/signed (Month, Day, Year) D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 31. Date filed (Month, Day, Year) 7601 OSLER DRIVE TOWSON. 32 Registrar's Signature State JUN 2 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760, 全

	For State Registrar		Sta	te of Ma	aryland	d / Depa <i>Ce</i>	artment of I rtificate of	Health a <i>Death</i>	nd Mer	ntal Hy	giene, Reg. No.	2008	21	0732
an cal	1. Decedent's Name JEFF		e, Last)	POTTI	ER					Date of De Month JUNE	eath Day 23	2008		ne of Death :56A M
er	4a. Facility Name (I	OSPITAL	OF BA	LTIMO	RE		4b. City, Town, C	E				County of Dea		
	5. Social Security N 213-52-8	3376	6. Sex 1 📉 M 2		62 (In yrs. li	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Min. 1	Date of Bi (Month, P /22/1	rth ay, <i>Year)</i> 1946	9. Bir	thplace (St ountry) MI	tate or Forei
ctor	Usual Residence of 10a. State MD	10b. County	N/A		_ ′	, Town or Lo					<u> </u>		-	de City Lim
Funeral Director	10e. Street and Nur 3510 L		TH ROAD				10f. Zip Code	21215			10g. Citiz	zen of What Co USA	ountry?	
þ	11. Marital Status 1 ☒ Never Marri 3 ☐ Widowed		ried Arn	s Decedent ned Forces?]Yes 2 X I es, Give ar or Dates:			Was Decedent of If Yes, specify Cub	an, Mexican,	n? (Specify Puerto Rica	Yes or No an, etc.)		14. Race - Ame Black, Whit Specify: V		ın,
Completed	(Spec		st grade comp	<i>leted)</i> lege (1-4or 5	5+)	(Give life.	dent's Usual Occu kind of work done DO NOT use retire	during most of	of working		16b. Kin	nd of Business NONE	•	
To Be C	17. Father's Name		Last)	PO	ITER			18. Mother	s Name <i>(F)</i> EKAH	irst, Middle	, Maiden S	Surname) MELNIk	OF	
	19a. Informant's Na JONATHA 20a. Method of Disp	AN AZRA			20b. PI	101	ng Address (Stree E. CHESA sition (Name of	PEAKE		5TH E	LOOR		N,MD	
	W Burial 2 4 □ Donation	5 ☐ Other (S	pecify)	I from State	BET		IEMORIAL 2. Name and Addr	1	6/25/			NDALLST		
	21. Signature of Fu	Service Service	Ligensiye	LI		1	3900 REIS					& BROS. SVILLE		
dical Examiner	Sequentially list conditions, if any leading Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
Physician/Mec	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 □ 9 □ Unknown	months?	1 [4 [Live birth	e of pregnancy 2 Fetal death 3 Ectopic pregnancy at time of death 5 Other (specify)						2	23d. Date of delivery Month Day Year		
þ	Part II. Other signif	icant condition	ons contributin	ng to death b	ut not resu	Iting in the u	nderlying cause gi	ven in Part I.			tobacco us	se contribute t	o the cause rob <i>a</i> bly	
Completed		phie	9 ~	eten	Sch				_	24a. Was auto perf 1 ∐Yes	s an opsy ormed? 2 X No	death?	utopsy find completion	n of cause
Be	25. Was case refer examiner?		Hospital	!: _			_/ Ot	26. Place		heck only	one)			
ation: To	27. Manner of Deat 1 ☐ Natural 2 ☐ Accident		ıg 📗	1 ☐ Inpatie Date of Inju (Month, Da	ıry	28b. Time o Injury	Wo	ıry at	28d		how injury	occurred	ecity)	
Certification:	2 Accident 3 Suicide 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)										d Number or F	ural Route	Number,	
Medical	29a. Certifier (Check only one)	h occurred at the vestigation, in my							use(s)					
X	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mont 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) An one Resilian and 15 walker are Bullon													
	30. Name and addr		who complete	0	leath (Item		Print)	wal	E-	Au	e. 1.	Sulto	ma	20
te ar	31. Date filed (Mon	th, Day, Year)	2809	32 Registr	ar's Signat	ure	well							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17

08-04797 Ernest Quick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 20733

			- For State Registrar	Cert	tificate of	Death		, ,	Reg. No.	
	Physicia		Decedent's Name (First, Middle,Last)					2. Date of De	ath	3. Time of Death
1	al Exami		Ernest Margus Quick					June 21,	Day Year 2008	2319 hrs
			4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or	Location of Dea		4c. County of D	Peath
			Prince Georges Hospital			Cheverly			Prince Geo	orge's
	Funeral		5. Social Security Number 6. Sex 7. Ad	ge (In yrs. las	st birthday)	If Under 1 Year	r If Under 24h	Irs. 8: Date of E	sirth(MM/DD/YYYY) 9	I. Birthplace (State or
	Director					Months Days		lin	F	oreign
	Director		216-13-4930 1XM 2 F		21 Yrs.			09/0	6/1986	Country) DC
	A		Usual Residence of Decedent 10a. State 10b. County	T40- 0't- '	Town or Location					10d. Inside City Limits
	w any		10a. State 10b. County							
	and sho	ō	DC	Wa	shing	ton				1 X Yes 2 No
	Maryland 28a-f show 1 at once,	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	the A	Ë	2302 Nicholson Street	t. SE		200	20		USA	
	with s 23	<u>ra</u>	11. Marital Status 12. Was Deceden	t Ever in U.S	3. 13. Was	Decedent of His	panic Origin? (lo- 14. Race - A	merican Indian, Black,
	eath item	Funeral	1 Narried 2 Married Armed Forces		If Ye	s, specify Cuban	, Mexican, Puer	rto Rican, etc.)	White, e	tc.
	ter d ", or		3 Widowed 4 Divorced If Yes, Give Year	No No	1	Yes 2 x No	specify:		Specify:	Black
	urs af tural	l by	15. Decedent's Education (Specify only highest grade co	mpleted)		's Usual Occupat		of work done	16b. Kind of Busin	
	2 hot	eted	Elementary/Secondary (0-12) College (1-4 or		during mo	st of working life	. DO NOT use r	etired)		
	36	ğ	12	,	Bark	oer/Coc	k		Priva	ite
	5-0036 Iled within 72 Hygiene. I other than the Medical	ompl	17. Father's Name (First, Middle, Last)		Dar			me (First, Middle	, Maiden Surname)	
	at He de the	e C		b Cr					queline	Tacobe
	2121 ould be fi Mental I marked ic event,	To B	Gregory Lorenzo Quicl 19a. Informant's Name/Relationship (Type, Print)	1, 51	19b. Mailing	Address (Stree			umber, City or Town,	
	., MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	-	Melvina J. Jacobs							on, DC 20020
-	ore, MC ss 1 and 2 s of Health an If item 27 her traums		20a. Method of Disposition	20h P		tion (Name of cer		Date	20c. Location - Ci	
	of Herit		1 X Burial 2 Cremation 3 Removal from S		rematory or oth			2010	200. 2000	ty or rown, clase
	Page nent ant:		4 Donation 5 Other Specify:		Linco	ln Ceme	terv (7/01/0	8 Brentw	ood, MD
	Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		Signature of Funeral Service Licensee							ood, MD uneral Svc
	0 8 9 7 7 1		dall t endled	~	172	22 N Ca	pitol	St, NW	, Washin	ngton, DC
	P hysician		23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.	d the death.	Do not enter th	e mode of dying,	such as cardia	or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
	Medical		Immediate Cause (Final disease a. Multiple Gunsh	ot Wound	ds					Death
	≟xaminer		or condition resulting in death) Due to (or as a cons							
		.	Sequentially list conditions, b							
		ē	if any, leading to immediate Due to (or as a consciouse. Enter Underlying Cause	sequence of)):					
		Examiner	(Disease or injury that initiated	equence of	١٠					
	ted ansit	Ĭ.	events resulting in death) Last Due to (or as a cons	requerioe or,	,·					
	760, icate be executed physician and the burial - trans	g	UNPENDED AMENDED							
	e be o	/Medical	The state of the s	,					Loo. Date (1	
			IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcomes 1 Live birth	me of pregn		al death 3	Ectopic preg	inancy	23d. Date of de Month	Day Year
	ox 68°	siciar	past 12 months?	at time of dea	th =	ner (Specify)	zotopio piog	,,		54)
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	the the	흥	one) 2 Medical Examiner: On the basis of exa	amination an						
	To To Con	Medical	and manner stated 29b. Signature and title of certifier		·	29c. Licens	e number		29d. Date signed	(Month, Day, Year)
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			 Name and abdyess of person who completed cause of Pamela E. Southall, MD Assistant Med 			l Penn Stree	t Baltimoro	MD 21201		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Alfred Norman Razgaitis 2008 2:00 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Be1 Air Harford 6. Sex 1 X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 218-18-6467 85 Director MAR 16,1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show notified at 1 □Yes 2 No Directo MD Harford Falston [] 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō he Medical Examiner must be 314 Whitaker Mill Road 21047 items 23a USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give 1943− Year or Dates: 1 Never Married 2 Married 0 Specify: White 1 ☐ Yes 2 ☐ No þ 3

Widowed 4 □ Divorced "natural", 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tool & Die Maker 12 Machine Shop marked other 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be should be Health and Mental George L. Razgaitis Pauline Kousha 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important; If item 27 is I any Injury or other traus 718 West MacPhail Rd, Bel Air, MD 21014
of Disposition (Name of Date 20c. Location - City or Town, State <u>Linda Thomas/Niece</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc 6/23/08 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 knu disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and/ Due to (or as a consequence of) Physician/Medical as the attending properties of IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a ☐Yes 2☐No 9□Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 24 hours after death. 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٥ 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) D Medical Center Bel Acr. Md

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Mary Lee Rolf 1557 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL CENTER Rosedale Baltimore 8. Date of Birth (Month, Day, Year) Sept. 15, 1927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 229 24 1950 80 Director Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 326 Grovethorn Rd. 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. ģ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Own Home permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other this any Injury or other traumatic event, I'm ang le. Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Floyd T. Pelter Clara E. Nease 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnny Arlin Rolf, Jr. (Son) 1988 Hill View Ct. Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 6/27/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service-License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. ohn W. 1407 Old Eastern Avenue Essex, Maryland 21221 Approximate
Interval Between
Onset and Death Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Hepato cellular cancer Sequentially list conditions, if any set in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy lor in the past 12 months? Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed? this certificate 2 🗆 No 1 ☐ Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐Yes 2 ☐ No s after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 2 Medical Examiner: and manner stated. the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 037612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN Square DR DR moHamad ALabrash 9000 Balto h. Day. Year) 32. Registrar's Signature 31. Date filed (Month, State Well of St. Come Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 20736 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** June 15, 2008 10:00 AM M Robert Rinehart Reed /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumber1and 342 Reservoir Avenue If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month Day, Year) Aug 27, 1920 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1**∑**M 2□F 87 Yrs 213-16-9528 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or iteme 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2√ No Director Allegany Cumberland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 342 Reservoir Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 2 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 0 rocket assembly explosiva operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be t and Men. George Sheridan Reed Binnie Pearl Middleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If Item 27 is 15801 Downing Street SW Cumberland, MD 21502 Roberta See/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 4 X Donation 5 ☐ Other (Specify) 21. Sinture Jeuneral Service Licensee Ronald S. Wad Director State Anatomy Board 655 W. Baltimore Street nt1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Careenoma moule /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires thet the death certificate be executed ned by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been s al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 🗆 No : After this certification in the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ (No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: / 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled in To the Hospitel racertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 00033260 June 17, 200 P 30. Name and address of person who completed se of death (Item 23a) (Type, Print) Kumar Gupta Cumberland Maryland 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 6 2008 Carlos S Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

			1 - For State Registrar	State Of Ivial			ate of Dea		ieritai i iy	Reg. N		20131
			Decedent's Name (First, Middle, Las	t)					2. Date of De	eath		3. Time of Death
	Physici: /Medic		Claire Elizabe	eth Smith					June		5, 2008	5:30 A M
Marie .	Examin		4a. Facility Name (If not institution, give				y, Town, or Locat			40	c. County of Dea	
			8427 Highridge 5. Social Security Number 6. Se		(In yrs. last birtl		Cllicott Mer 1 Year If Un	City nder 24 Hrs.	8. Date of Bi	rth	Howard	
	Funeral Director		219-28-0521 Usual Residence of Decedent			/rs. Month		ırs Min.	8. Date of Bi (Month, D April	18, Year	.932 Ma	thplace (State or Foreign ountry) aryland
	dand ow		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Mary a-f sh	to	Maryland Howard		E11	icott	City					1 □ Yes 2/□ No
	or 282	Jirec	10e. Street and Number			10f. 2	Zip Code			10g. C	itizen of What Co	ountry?
	23a ust b	ral	8427 Highridge Ro	_			21043				USA	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Mudical Eventinal must be notified at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:			cedent of Hispanic becify Cuban, Mex 2 X No Spe		ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: Whi	e, etc.
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lan	ld be lental ked c	To Be	George Vincent Wi	se				Marion	Elizal	oeth	William	nson
ary	shoul and M s mar umat	-	19a. Informant's Name/Relationship (7		19b.	Mailing Addre	ss (Street and Nu					
Σ	and 2 salth a 27 is		Ronald P. Wise, B	rother	15	9 Sanf	ord Aven	ue Cat	onsvil:	le,	Maryland	d 21228
ore	of He fitem		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐	Domouni from State	20b. Place of cemetery	Disposition (N , crematory o	lame of r other place)		Date	20c. l	Location - City or	Town, State
Ë	Pag ment tant: I		4 ☐ Donation 5 ☐ Other (Specify)	Metro		ory Inc.					, Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any Injury or other tra once.		21. Signature of superal Service Licent Thomas Gregor	Ly		22. Name Crema 299	and Address of Fa ation So Frederic	ciety k Road	Of Mary Baltin	ylan nore	d, Inc.	and 21228
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the cause on each line	ne death. Do n	ot enter the m	ode of dying, such	h as cardiac	or respiratory a	arrest,		Approximate Interval Between
way.	Physician		Immediate Cause (Final disease or condition		reatu							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence o	f):						
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99	± 5, a		IF FEMALE:									
O. Box	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3 Ectopie 5 Other	c pregnancy (specify)				23d. Date of de Month	olivery Day Year
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	fing After funer	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28d. Describe	how inj	ury occurred						
Division	l or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, far (Specify)	m, street, fact	ory, office		28f. Location City or To	(Street a wn, Sta	and Number or R te)	lural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of liner: On the basis of e and manner state	examination and	, death occurr d/or investigati	ed at the time, da ion, in my opinion,	ite and place, , death occur	and due to the	e cause , date a	(s) and manner a nd place, and du	as stated. e to the cause(s)
	To the within 2 To the сотры	Me	29b. Signature and title of certifier			2	29c. License numb	ber		29d. D	ate signed (Mon	th, Day, Year)
	. , , , , ,		· (· ()	1/			D35	214		6	25/04	
	į.		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, Print)			- 0			
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Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SCH MEDES MARY Physician Month 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 105 Cromwell Ave Ferndale Anne Arundel 6. Sex if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug 10, 1929 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2 F 78 214-26-5788 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If Nem 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examine: roush be notified as 1 □Yes 2 ₩No Director MD Ferndale Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21061 Funeral 105 Cromwell Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2**XX**No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2ÑŽINo If Yes, Give Year or Dates: Specify: ģ Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be file of Health and Mental H Be Elizabeth Schaeffer Pembrooke Krauk ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 518 Hawthorne Rd, Linthicum, MD 21090 Henry Joseph Schmedes III Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) St. Paul's Cemetery June 25, 2008 Upperco, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fink Funeral Home, P.A. M01148 426 Crain Hwy S., Glen Burnie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and-trar Due to (or as a consequence of): attending physician a for use as the burial Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Pregnant at time of death 5 Other (specify) P.0. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, cate has been si page 2 should b 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform certificate Division of Vital 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending investigation Japital o. -4 hours after dea. -eral Director: Afte 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after

To the Funeral Directory

completely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifiq 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS MO21401 441 31. Date filed (Month, Day, Year) 32 pegistrar's Signature State Registrar

		ı	For State Registrar	State of M	laryland /		rtment of H				iene _{eg. No.} 20	0.8	20739
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	Director		224-24-6896	TOM ZX	9.0	Yrs.				June 1	3,1918	3	WVA
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Loc	ation				·	10	d. Inside City Limits
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	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Eventral must be notified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W	/as Decedent of H Yes, specify Cuba	ispanic Or	rigin? (Spec	ify Yes or No-		- Americ	
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an	d be ental ked o	To Be	Marion R. Lo							na Mar		- /	
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	nd 2 alth a 27 is		Joyce Reynold	ls /daugh	ter	21	0 Potom	ac C	ourt	Sykes	ville	MD	21784
re,	of Hei		20a. Method of Disposition		20b. Place		ition (Name of atory or other plac	e) !	Dat	te	20c. Location -		
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Вох	eath certific attending p for use as t	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	e of pregnancy 2 Fetal deat	th 3 🗆	Ectopic pregnancy	/			23d. Date Mor	e of delive	ry Day Year
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Ф.	that the de ned by the detached		Part II. Other significant conditions	contributing to death I	out not resulting	in the un	derlying cause give	en in Part I	 I.	23e. Did tol	nacco use contr	ibute to th	e cause of death?
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Vis.	il or Attend after death Director: d in by the f	iji	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	jury - At home, f	farm, stre	et, factory, office		28	f. Location (St	reet and Number	er or Rura	Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best miner: On the basis and manner s	of examination a	ge, death and/or inv	occurred at the tin estigation, in my o	ne, date a pinion, dea	nd place, ar ath occurred	nd due to the c I at the time, d	ause(s) and ma ate and place, a	nner as st	ated. the cause(s)
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5			DR Samantha	Dreyer	9000	FRAN	KLIN So	sua	re D	R Bo	LUON	nd Z	21237
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08-04833 Michele Spurrier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea		3. Time of Death
ledical Examine		Michele Windsor Spurrier	June 23, 2	2008	1529 hrs
3 X.	ı	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 104 Gadd Drive Centreville	1	4c. County of Dea Queen Anne	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs		rth(MM/DD/YYYY) 9. B	
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e Mary or 28a-	9	10e. Street and Number 10f. Zip Code 10d. Gadd Drive 21617	1	log. Citizen of What Co	untry?
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imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Interest is marked other than "natural", or other traumatic event, the Medical Examiner.		17. Father's Name (First, Middle, Last) Robert Pulliam Helen D	,	waden surrame)	
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Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is an injury or other traumafice.	- 1	Jeffrey Scott Beard (Son) 2011 Leland Avenue Bard (Son) 2012 Leland Avenue Bard (Son) 2014 Leland Avenue Bard (Son) 2015 Place of Disposition (Name of cemetery, 2015)	altimore Date	20c. Location - City	t 21220 or Town, State
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director and the completely filled in by the funeral director and the completely filled in by the funeral director and the completely filled in by the funeral director and the completely filled in by the funeral director and the completely filled in by the funeral director and the completely filled in by the funeral director and the completely filled in by the funeral director and the completely filled in by the funeral director and the completely filled in by the funeral director and the completely filled in by the funeral director and the completely filled in by the funeral director and the completely filled in by the funeral director and the completely filled in the completely f	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated		e and place, and due to	the cause(s)
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (A. June 25, 2008	flonth, Day, Year)
5 2		30. Name and address of person who completed cause of death (Item 23a)	ME	1 55,75 25, 2000	
		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimo	re, MD 2120	1	
Sta Registr		31. Date filed (Mohth, Day, Year) 108 Registrar's Signature	Т.		

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** codore 5:10 P M /Medical (If not institution, give street and number 4c. County of Death Examiner Baltimore Vorthwest If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 23, 5. Social Security Number Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral X** M 2□ F New York Months Days Hours 113-14-4944 82 May 1926 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 → No **Funeral Director** Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2117 Meadowview Drive 21207 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If ¥es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 □Yes 21☑No Specify. Specify: White Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administrator Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sadowy Stephen ပ Julia Dobrianska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Collum Great Glen, Williamsburg, (Niece) <u>Virginia</u> 23188 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XXX*remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 06/27/08 Catonsville, MD 21228 22. Name and Address of Facility Oring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licenses 400333 8728 Liberty Road, Randallstown, MD. 21133-4784 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, ohysician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛂 🗖 0 1 Hipatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LaMant C. Smith, M.D., 5401 Old Court Road, Randallstown, Maryland 21133 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 6 2008 Registrar

P.0.

0/23/2008 T.O.D. 1045 A.M. Baltimore, Maryland 21215-0036 Staner, Clayton Moco 108300 Division or Vital Records, P.O. Box 68760,

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er dea items	nue	11, Marital Status	ind ON Manufac	12. Was Decedent Armed Forces?		S.	13. W	as Deceder Yes, specify	nt of H y Cuba	lispanic Origin? (S _l an, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	14. Race Black	- America , White, e		t
urs aft	by F	1 ☐ Never Marr	ried 2 X Married 4 □ Divorced	1 XYes 2 ☐ if Yes, Give Year or Dates:	INO		1[□Yes 2X	No.	Specify:			Specify:	Whi	te	
72 hou	sted	(Spec	15. Decedent's	Education grade completed)		(Give ki	ent's Usual C	done d	during most of wor.	kina	16b.	Kind of Bus	iness/Ind	ustry	
vithin ne.	Completed	Elementary/Seco		College (1-4or	5+)		life. DO	ONOTuse ma tic :	retired	d) _		F	ducati	OB		
filed v Hygie Ither t		17. Father's Name	(First, Middle, La	ast)		ria		macic.	Tall	18. Mother's Nan	ne (First, Middle					
lid be fental rked o iic eve	To Be	Howard S	. Stein	er						Florence	e M. Mi	11e:	r			
2 shou and A is mai	Г	19a. Informant's Na				1	_			and Number or Ru					Code)	
and tealth		Elizabet		er (wife)	20h B			Sarato		Drive :	Bel Air		D 2101 Location - C		wn State	
ages 1 nt of 1- : If Ite			☐Cremation 3	☐Removal from State	_ c	emetery	ı, crema	atory or other	er plac	i				-		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 21. Signatu of Ft	5 Other (Spe uneral Service Ki		pel	LAI		em. Ga		ss of Facility Sc	27-2008	1	el Air			Rollir
Depa Impo any is		144	Colle	4			In	c. 610	0 W	. MacPha	il Rd B	el A	Air, M	D 21	014	Deirii
74.16		23a. Part1. Enter t shock, or hea	the disease, or co art failure. List or	omplications that cause nly one cause on each li	d the death ne.	n. Do no		-			or respiratory	arrest,			Approxi	mate Between nd Death
Physician		Immediate Cause disease or condition resulting in death)	(Final on	a	ANO			Di	€27	Ase						
/Medical Examiner		Due to (or as a consequence of): STENOS is														
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ne dea the att hed fo	sici	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4□Pregnant a 9□Unknown				Other (spec		,			Mon	un	Day	Year
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quires n sign uld be											1 🗆] Yes	2□ No	3 Prob	ably 4	Unknown
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The sate h	Com											formed	3/ d	eath? □Yes	2 № No	
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Phys er this eral di	: To	1 ☐ Yes 2 ☐ 27. Man of Dea		28a. Date of Inj	ury	ER/Outp	ime of		c. Inju	4 ☐ Nursing F	lome 5 ☐ Re 28d. Describ			. ,	y)	
ath. pr: Afte	atio	1 Matural 2 ☐ Accident	5 ☐ Pending investiga		ay rear)	m	ijury	М		Yes 2 □ No						
or Atte ter de ilrecto n by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin		jury - At ho tc. <i>(Specif</i>	ome, far	m, stre	et, factory,	office		28f. Location City or T			r or Rura	l Route l	Vumber,
pital o		29a. Certifier	1 Certifying	Physician: To the best	of my kno	wledge.	. death	occurred at	t the ti	me, date and place	e, and due to th	e cause	e(s) and mai	nner as s	tated.	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Medical	(Check only one)		xaminer: On the basis of and manner s	of examina											se(s)
To th withir To th comp	Me	29b, Signature and	d title of certifier					29c. l	Licens	se number			Date signed	(Month,	Day, Yea	ır)
4		1	1/000		171)			D	45921		7	UNE	23	400	-008
10		30. Name and add	fess of person w	ho completed cause of A HM Q Q D	death (Iten	n 23a) (1	Type, P		14/1	ONTON R	LA S	ONT A	171A	150	₩(<u>)</u>	AIR
Sta	ite	31. Date filed (Mor	nth, Day, Year)	32. Regist	rar's Signa	ture	المم	20		. 1010	-) 3	· () C		1/0		1.416
Registi	ar	JUN	1 2 6 ZUU	O free Della	A Party	Sal R	346									

State Registrar

DHMH 17 Rev 1/2001

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32. Registrar's Signature

Bank more, m) 21202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST.

31. Date filed (Month, Day, Year) 2008

			1 - For State Registrar	ate of Marylan	d / Depa <i>Cei</i>	artment of I rtificate of	lealth a Death	and Mental Hy	giene Reg. No. 20	08 20744
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Patricia Ann Troutma	ın				2. Date of De Month June		Year 3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give stree 7972 Nol Park Court 5. Social Security Number 213-54-4967 6. Sex	7. Age (In vrs. I	last birthday) Yrs.	4b. City, Town, G16 If Under 1 Year Months Days	en Bur	mie	th v, Year)	of Death Arundel 9. Birthplace (State or Foreign Country) Maryland
	D	or	Usual Residence of Decedent 10a. State 10b. County MD Anne Arur	10c. City	y, Town or Lo		·····		, 13.17	10d. Inside City Limits 1 □Yes ※ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 7972 Nol Park Court	, Unit 104			1061		10g. Citizen of W	States
036	ours after de ral", or items Examiner m	2	Never Married 2 Married 1	Vas Decedent Ever in U. Armed Forces? Yes Monormal No Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cut 1 ☐ Yes 2 X No		igin? (Specify Yes or No n, Puerto Rican, etc.) :	Black	e - American Indian, k, White, etc. : White
21215-0036	within 72 ho jene. r than "natu the Medical	Be Completed	15. Decedent's Educatio (Specify only highest grade con-	n npleted) College (1-4or 5+)	(Give life. I	dent's Usual Occu kind of work done DO NOT use retire	during mos	· ·	16b. Kind of Bus	siness/Industry
Maryland 2	ould be filed Mental Hyg Iarked other iatic event, i	To Be C	17. Father's Name (First, Middle, Last) Francis Franklin Tr				18. Moth	er's Name <i>(First, Middle,</i> Ooris Evelyr	, Maiden Surname n Dawson	θ)
	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (Type. F Kimberly L. Young -	Daughter	104B	Scoup Co		Summerville	e, SC 294	483
Baltimore,	Pages 1 ment of H tant; if Iter jury or oth	1	20a. Method of Disposition 1 Burial 2 Micremation 3 Remo	val from State	esteracier Cre	sition <i>(Name of</i> natory of other pla INGE Matory		Date 6-24-08	Odento	City or Town, State
Ball	permit Depar Impor any in		21 Signature of Funeral Service Licens	Class	1	.328 Sul _I	hur S	opring Rd.,	Arbutus,	MD 21227
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	ons that caused the death use on each line. Must Subject to (or as a consequence)	nthe				rrest,	Approximate Interval Between Onset and Death
68760 Kg	ficate be executed a minima is the burial-transit	edical Examiner	Sequentially list conditions, the many course. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b	Due to (or as a consequ						
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	f yes, outcome pf pregna I□Live birth 2□Feta I□Pregnant at time of de I□Unknown	death 3	Ectopic pregnand Other <i>(specify)</i>	:y		23d. Date Mor	e of delivery nth Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contribu	ting to death but not resu	ulting in the ui	nderlying cause gi	ven in Part I	1 23e. Did t		ibute to the cause of death? 3 Probably 4 Unknown
Vital Records,	ysician: The law I is certificate has be director, page 2 sh	Completed	25. Was case referred to medical				OC Dies	24a. Was auto perfo 1 Yes e of Death (Check only o	psy p prmed? d 2 XNo 1	Vere autopsy findings available rior to completion of cause of leath? ☐ Yes 2☐ No
	Physicia r this cert ral direct	: To Be	examiner? 1 Yes 2 No Hospi	tal: 1 Inpatient 2 I	ER/Outpatien	1 JU DOA	her: 4 🗆 Nı	ursing Home 5 Resi	dence 6 Othe	
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Be. Place of injury - At ho building, etc. (Specify	Injury ome, farm, str	M 1	rk?]Yes 2□	No	Street and Numbe	er or Rural Route Number,
	lospital o	cal	29a. Certifier (Check only (Ch	n: To the best of my kno	wledge, death	vastigation in my	oninion do	nd place, and due to the	cause(s) and man	and due to the cause(s)
)	To the P within 24 To the F complete	Medical	29b. Signature and title of certifier WWW 30. Name and address of person who comple Kann M Dwyg 31. Date filed (Month, Day, Year) JUN 2 6 2008	and manner stated.	no	29c. Licen	se number	for	29d. Date signed	(Month, Day, Year)
r	\$		30. Name and address of person who comple	ted cause of death (Item	1 23a) (Type,	heithry	suit	134 Pase	dena l	MD 2/122
9	Sta Registr	ite ar	31. Date filed (Month, Day, Year) JUN 2 6 2008	32. Registrar's Signa	ture	رع				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar State of Maryland / Department of Health and Mental Hygiene Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** della lerrelonge Zac /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Baltimore Northwest Kandallstown Hospice 5. Social Security Number If Under rear If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 85 Months Days Hours Min 216.15.944 1 □ M 2 **X** F Yrs Director Jamaica 98 24 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Wedical Examiner must be notified at Baltimore Reisterstown **Funeral Director** MD 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 21136 USA Koac Nemilia 11. Marital Status 2. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐Yes 2 ☑ No Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Black 9 Specify. Specify: 3 Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mential Hygiene important: If item 27 is marked other than "any injury or other traumatic event, the Mag once. Elementary/Secondary (0-12) College (1-4or 5+) omestic Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Latherne 19a. Informant's Name/Pelationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number Lity or Town, State, Zip Code) Ruby Avenue 3401 Baltimore MD 21215 Callaway 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ⊠Burial 2 ☐ Cremation 3 Removal from State 06/28/08 Memorial Park Windsor Mill, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vaughn C Greene Funerl Service 8728 Liberty Road Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) erebead /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 ment 1 ☐ Yes 2 No Month Day Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ ¥6 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an autopsy performed 1 □ Yes 2 **∑** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Not Pice 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of the course o completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ٥

Registrar

State

mede!

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day,

^{Year)} 2008

31. Date filed

3

32. Registrar's Signature

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Year 9:07 PM 23 JUNE 2008 ONAL THONNTON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JosepH BAltiMORE 8. Date of Birth (Month, Day, Year) TUNE 3, 19 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Min 216-68-3994 1 M 2□ F 52 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylau Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Examiner must be notified at once. 1**⊠**Yes 2□No BAltiMORE Director 10e. Street and Number 10g. Citizen of What Country? View Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Şecondary (0-12) College (1-4or 5+) DisA Bled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) View BAHO. MD. 21229 K. Gray-SisTer ENISE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1. Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Dicense 21229 23a. Part 1. Enter the disease, or complicated is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HEPATOCELLULAR 3 YFARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown UNKNOWN Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

the signed by has

3altimore, Maryland 21215-0036

this certificate Hospital or Attending hin 24 hours after death the Funeral Director:

within 2

State Registrar

Medical

29b. Signature and title of certifie

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year) JUN 26 2008

29a. Certifier

(Check only one)

6114 CAMPFIRE, COLUMBIA, MD 2104

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0026327

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04722 2008 20747 State of Maryland / Department of Health and Mental Hygiene Raymond Anthony Urbanski Certificate of Death Reg. No. 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day June 19, 2008 hysician/ 1023 hrs Raymond Anthony Urbanski Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Queen Anne's Centreville 520 Chester River Beach Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 11-8-1945 Country) MD 62 Director 214-44-8296 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 X No Grasonville Oueen Anne's s 23a or 28a-f show e notified at once. or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If liten 27 is marked other than "natural", or items 23s or 20. findury or other traumatic event. 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number USA 21638 520 Chester River Beach Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral White, etc Armed Forces? 2 X Married 1 Never Married 1 X Yes Yes 2 No specify. Specify: White If Yes, Give Year 3 Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Payroll Auditor Exxon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pauline Saynuk Be Sigmund Urbanski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21638 19a. Informant's Name/Relationship (Type, Print) 520 Chester River Beach Rd. Grasonville. MD Carolyn Urbanski - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dundalk, MD 6-23-08 Holy Rosary Cem. Donation 5 Other Specify: 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and ysician failure. List only one cause on each line. Death Medical a Narcotic (methadone) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed AMENDED #23a,27&28a-f,perME,g881 7/31/08 TT Physician/Medical X UNPENDED physician a 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Month Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown 6 24b. Were autopsy findings available Completed 24a. Was an Records, prior to completion of cause of autopsy death? icate has t page 2 sh performe Yes 2 V No certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica of Vital Be Other₄ Nursing Home 5 Residence 6 Other: Scene Hospital: 1 ER/Outpatient 3 Inpatient 2 this 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After 1 Yes 2 X No Certification: 1 Natural 5 Pending Division 6/19/08 Fnd 10:18 am Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 520 Chester River Beach Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide rasonville, MD within 24 hours a To the Funeral I determined (Specify) residence 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 1 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier OCME June 20, 2008 OCME. rson who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Thendore M. King, Jr., MD.

State

Registra

31. Date filed (Month, Gan Year)

2008

37 Registrar's Signature

ORIGINAL

amend #5,14&22 Per FH G880 | Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical cility Name (If not institution, give street and 4b. City Town, or Location of Death Examiner Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 217-40-0136 **Funeral** Days 1⊠M 2□F Apr 19, 65 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the firem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show urry or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b County of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director Baltimore MD N/A 10f Zin Code 10e. Street and Number 1553 Cole Street 21223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 2 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk security guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1553 Cole Street Baltimore, MD Mary Rodgers/niece 20b. Place of Disposition (Name of Cemetery crematery of other place) West Arundel 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Department o Important: If any injury or atory 6-26-2008 Odenton, No. 22 Name and Address of Facility Ambrose Funeral Home \$1328 Sulphur Spring RD: Baltimore Baltimore, MD 21201 Arbutus Md Crematory tre of Funeral Service Licensee irector 23a. Part1 Enter the discase, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical equence of) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner ending physician and use as the burial-tran Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes Completed 24a. Was an 1□ Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 → 2 ER/Outpatient 3 DOA 1 Impatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours To the Funeral 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License numbe 29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

TX□Yes 2 □ No

unk

Maryland

14. Race - American Indian.

Specify: black White

Street

Approximate Interval Between Onset and Death

Black, White, etc.

Year

2007

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business/Industry

Wells Fargo

20c. Location - City or Town, State

23d. Date of delivery

Day

2 No 3 Probably 4 Hriknown

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Year

Month

2 No

USA

N/A

Dav

1943

28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) (Type, Print) (Item 23a) **ORIGINAL**

State

Registrar

31. Date filed (Mor

Day, Year) V 2 6

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 ARGO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALY If Under 1 Year ALTIMO er 1 Year | If Under AGNES ty Number 6. Sex NOSPOTAL 7. Age (In vrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) last birthday) 5. Social Security Number Days **Funeral** Months 216-36-9669 Hours 1 ☐ M 2 ★ F Yrs. MARCH 03. MAR Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director MARYLAND Citizen of What Country? 10e. Street and Number A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No ģ 3 ☐ Widowed 4 ☑ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ITHGRADE 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be REDERICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SHARLENE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of acility 21. Signature of Funeral Service Licensee JR. FUNERAL HOME BALTO. FULTON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as regnerous of): **Physician** /Medical Examiner ischemia tensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner atterosclerotic Hospital or Attending Physiclan: The law requires that the death certificate be executed severe burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical for use as the the attending IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 months? 1☐ Yes 2☐No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, 2 pe 3 Probably 4 Unknown 1 □ Yes 2 □ No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Yes 2 No 1_Inpatient 2 ER/Outpatient Medical Certification: To Division or After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar E. REED

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31. Date filed (Month, Day, Year)

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Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** elen A WALKER 6 00 /Medical Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Examiner 42 timore 8. Date of Birth Pay, Year) 10. 8. 1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. **Funeral** 217-05-9222 Months Days Hours Min. 1 □ M 2 🕶 F 8 Director Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10h. County Department of Health and Mental Hygiene innertment, or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Madical Examinar marst be natified at once. 10c. City, Town or Location MD Director timore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21230 usA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Kind of Business/Industried Eval 15. Decedent's Education (Specify only highest grade completed) (Cive kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government ustodian 17. Father's Name (First, Middle, Last, 18. Mother's Name (First Middle, Maiden Surname Be Bernard **Owens** omeri Jame da 19b. Mailing Address (Street and Number or Rural Route Number Informant's Name/Refationship (Type Balto, mo valker 231 5 21223 Edmondson Husbana, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6.30.08 Crownsville, MD Vaughn Haili Greene Funeral Services of Balto. Nati P:1(e (21229) 21. Signature of Funeral Service Licer reene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PARICINSONS **Physician** DUSCASE YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi and Due to (or as a consequence of): /ブピノピハ ノングリんでん Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnapt 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed by 1 23e. Did tobacco use continute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 1 No 3 Probably 4 Unknown director, page 2 should Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? e Hospital or Attending Physician: The 124 hours after death. e Funeral Director: After this certificate I letely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Hospital: 1 □ Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the To the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D158 Y 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAWTENCE BOAS mb 54 Scott Adam Rd Suite 202 Cockeys Ville no 21030 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 6 2008 Registrar

Hephen Waters Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04806 State of Maryland / Department of Health and Mental Hygiene amend #10c Per FH G880 entificate of Death 2008 20751 **UNK UNK** 1- For State 1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ 0544 hrs June 22, 2008 ★ Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** 204 East Montgomery Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex **Funeral** Davs Hours Min Months Directo: 13-06-1393 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 10a State Yes 2 No Baltimore 28a-f show 'natural", or items 23a or 28a-f shov Examiner must be notified at once. Director 109. Citizen of What Country 10f, Zip Code 10e. Street and Number 21207 SA od bine 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 Married Yes Black Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygierer and 1 flea 17 is marked other than "natural", o ant I fleat T is marked other than "natural", or other traumatic event, the Actival Examiner. f Yes, Give Year Divorced Widowed ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bricklayer 21215-0036 18.Mother's Name (First, Middle, Maiden Surname 17, Father's Name (First, Middle, Last Waters Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address ို 19a, Informant's Name/Relationship (Type, Pri timore, MD Ave. Woodbine ackson Brother Kennard 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition permit. Par.
Department of ...
vportant: If'
vor of' 1 Burial 2 Cremation 3 Removal from State Baltimore Park Kina Donation 5 Other Specify 21. Signature of Funeral Service Licen Name and Address of Facility reene Funeral Services 5151 Bultimore Htl. Fixe Balto. Mi ghn Balto, Mu. Approximate Interva 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hysician Between Onset and failure. List only one cause on each line Death M. dica a. Multiple Gunshot Wounds Immediate Cause (Final disease ∠xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and . X AMENDED 28a-b, perME, g882 8/11/08 TT Physician/Medical UNPENDED attending physician for use as the burial -The law requires that the death certificate be Box 68760. 23d, Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Year 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ş 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autonsv death? certificate has performed? 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital Be Other₄ Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 DOA FR/Outpatient 3 After this 1 V Yes 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Subject was shot Certification: Jun 22, 2008 Natural Yes 2 V No 5:40 am Fnd death. Director: Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc hours after 3 Could not be Suicide or Town, State) 204 East Montgomery Street, Baltimore, MD within 24 hours at To the Funeral I (Specify) Sidewalk 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie June 22, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

Jack Titus MD. De

111 Penn Street, Baltimore, MD 21201

Deputy Chief Medical Examiner

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Month **Physician** June 11, 9:45 AM James Wentzel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CEci1 Union Hospital E1kton | Months | Days | Hours | Min. | Month, Day, Year | Mar 8, 195 7. Age (In yrs. last birthday) Birthplace (State or Forei Country) Social Security Number **Funeral** unk 1**X** M 2□ F 54 206-46-3535 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2√ No MD Ceci1 E1kton Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 Conley Court 21921 USA Funeral 12. Was Decedent Ever in U.S.unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Be Completed by 3 Widowed 4 Divorced unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk lunk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 106 Bow Street Elkton, MD 21921 Union Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state State Anatomy Board 655 W. Baltimore Street Ron III S Director Baltimore, MĎ 21201 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MASSIVE GI /Medical Due to (or as a consequence of): Examiner CIRRHOSIS Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Hepolitis burial-trar Due to (or as a consequence of) Vital Records, P.O. Box 68760, physician Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CHWWII 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed?. 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled i by the 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier b. N. Mundon 15 118/22 10065733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) street, sunt MD 21921 33 BLKTON RAD . V - PULA 118 NORTH NARAYANA 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 6 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 19. 2008 8:50 AM M <u>Bernard F. Wiessner</u> 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year) Aug 30, 1926 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours Min. Maryland 81 217-20**-**1856 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Donegal Drive 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 XX If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sales representative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Anthony Wisniewski Elizabeth Fabiszak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen Wiessner/spouse 419 Donegal Drive Baltimore, MD 2186 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Funeral Service Licensee ²³ Name and Address of Excelling Board 655 W. Baltimore Street irector 21201 Baltimore, MD 23a. Part1 Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) METASTATIC CANCE MONTHS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\tag{Nursing Home} \) 5 \(\tag{Residence} \) 6 \(\textbf{Xother} \) (Specify) \(HOSP(C) \) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Experience must be notified at

tem 27 is marked other other traumatic event,

item 27

permit. Pages Department of I Important: If its any injury or o

Director

by Funeral

Completed

Be

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MD

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Balfimore, Maryland 21215-0036

Examine attending physician for use as the buria

certificate has been signed by the rector, page 2 should be detached To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

Division of Vital Records, P.O. Box 68760,

Physician/Medical Completed Be Certification: To

F FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be

29c. License number D64395

29d. Date signed (Month, Day, Year) JUNE 19,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 N CHARLES ST, SUITE 209 BALTIMERE, MD 21204 DANIEUE OUBERMAN, MO

State Registrar

Medical

and manner stated.

State of Maryland / Department of Health and Mental Hygiene? $\Omega \Omega \Omega$

			For State Registrar	State of Ivial	Ce	ertificate of	Death		g. No.	20/54
			Decedent's Name (First, Middle, La.			-		2. Date of Death Month	Dev Yeer	3. Time of Death
	Physicia /Medic	- 20	JULIA	WHIT	3			~ /	14 2008	12:30P M
	Examin	er	4e. Fecility Name (If not institution, give				or Location of Deeth		4c. County of Dee	th
***	Funoral		Manor Care Rolan 5. Social Security Number 6. S		'In yrs. last birthday	If Under 1 Year		8. Date of Birth	9. Bir	thplece (Stete or Foreign
	Funeral Director			□M 2∏F 7	5 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Dey, Nov 21,	1932 Mar	yland
	land ow		10a. State 10b. County	1	IOc. City, Town or L	ocation				10d. Inside City Limits
	Man a-f sh	ctor	MD		Baltimo	re				1√∑Yes 2□No
	with the 3s or 28	I Director	10e. Street and Number 4669 Falls Road			10f. Zip Code 21	209	10	g. Citizen of What Co USA	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "natural; or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	te, etc.
Ö	2 hou	ted	15. Decedent's Ed	ducation	16a. Dec	edent's Usual Occup	petion during most of work		6b. Kind of Business	Industry unk
Maryland 21215-0036	within 7 iene.	Completed by	(Specify only highest graves Elementary/Secondary (0-12) unk u	College (1-4or 5+)	lite.	DO NOT use retire	diffing most of work d)	(III)		
5	illed with Hygiene other the	Be C	17. Father's Name (First, Middle, Last,					e (First, Middle, M	aiden Sumame)	
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	and 2 sho selth and n 27 is ma		19a. Informant's Name/Relationship (Charlene English				and Number or Aut Court Bal		City or Town, State, 10 21222	Zip Code)
Baltimore,	Pages 1 annent of Herant of Herant of Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specif		20b. Place of Disp cemetery, cri	position (Name of ematory or other pla		Date 2	0c. Location - City or	Town, Stete
Balti	permit. Page Department of Important: If any injury or once.		Of Cine - I Financi Consign I						Baltimore	Street
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	Physician		shock or heart failure. List only Immediate Cause (Final disease or condition			ADREN	VAL (ARUN	10 m A	Onset and Death
X 3	/Medical Examiner		resulting in death)		consequence of):					
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	uted I Insit	Examiner	Sacuentially list rond ions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	220 10 101 20 2	33,133433,133 317.					
90,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
68760,	physic physic the t	edical		d						
.O. Box 6	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	☐Ectopic pregnand	у		23d. Date of de Month	Day Year
Ω	that the hold by detail	y Ph	Part II. Other significant conditions of	contributing to death but	not resulting in the	underlying cause g	ven in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
rds	w requires that been signed be should be det	ed by						1 🗌 Yes	s 2□No 3□P	robably 4 Unknown
Vital Records,	The law re ate has bee page 2 sho	Completed						24a. Was an autopsy perform	prior to death?	
<u>ta</u>	lcian: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					th (Check only one		
of V	hys his	L _o	1 Yes 2 No	Hospital:		ent 3 DOA		·	nce 6 Other (Spe	ecify)
ion	Attending Part death. ector: After Iby the funera	atlon:	27. Manner of Death Saturel 5 Pending	28a. Date of Injury (Month, Day)		Wo	ny at ork?]Yes 2 □ No	28d. Describe how	w injury occurred	
Division	if or Attending Patter death. I Director: After to in by the funer.	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		y - At home, farm, s (Specify)	street, factory, office		28f. Location (Str. City or Town,	eet and Number or F . State)	lural Route Number,
	Hospita 4 hours Funerel ety fille	edical C	29a. Certifier Check only one) Cartifying Pr	nysician: To the best of niner: On the basis of e and manner state	xamination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Mon	th, Dey, Year)
,	- > - 0		I ham	N.D		D	5059107	-	06-04	-2008
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	n Print\				
			31. Date filed (Month, Day, Year)	210 BUSINE	SS CENTE	RDRIVE	KEIST	ERSTOW	N, MO	21136
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 6 200	8 Mayor	A A	WED .				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Month **Physician** June 11 36 AM AND. WATT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hapkins
5. Social Security Number Barriew Medical Center a Himore
1 Year | If Under 24 Hrs. 8. Date of Birth Nov 15, 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Funeral ^Y1955 Days Hours Min. 1 X M 2 □ F Months 52 218-68-8663 Director Usual Residence of Decedent 10d, Inside City Limits UNK should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Wedleal Event in at intal be realthed unk unk 1 ☐Yes 2 ☐ No Director MD unk 10g. Citizen of What Country? 10e. Street and Number unk 10f. Zip Code USA Funeral 12. Was Decedent Ever in U.SINK 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? unk 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Maryland 21215-0036 1 ☐Yes 2 X No Specify white ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18 Mother's Name (First, Middle, Maiden Surname) unk Be (17. Father's Name (First, Middle, Last) unk ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hopkins Bayview Hospital 4940 Eastern AVenue Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5፟XOther (Specify) in state 21. Signatu 11 Finn, ar Service Licensee Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician one week Metabolic cvere /Medical Due to (or as a consequence of): Examiner Multiong an D Due to (or as a consequence of) one week squentially net conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Hemorrhagic and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical Sophagea the I as IF FEMALE: for use yes, outcome of pregnancy
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To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AM:N ITH#25.peri HVS. 1680.6/26/08.WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 25, VIRGINIA OLENE YOUNG JUNE 0153 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ X Director 229-32-0501 78 Mar. 9, 1930 Virginia Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☑ Yes 2 ☐ No Directo Maryland | Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 223 E. Crocker Drive 21014 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cafeteria Worker Public School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph (unk) Ross Mae (unk) Testerman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin B. Young / Son 1867 Alton Trail, Greenville, NC 27834 if Health in tem 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Grdn 6-28-08 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part1. Ent.: the disease, or complications the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final nounon tayo **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ NSMO 1 Yes 2 No 3 Probably 4 Unknown Completed Weakeress 24b. Were autopsy findings available prior to completion of cause of death?

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DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

D.O. 500 Upper Che

32. Registrar's Signature

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Nesseen

31. Date filed (Month, Day, Year)

JUN 2 6 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Dhusia	ion/	Registrar 1. Decedent's Name (First, Middle,L	ast)	Cer	uncate of L	Jealii		Re 2. Date of Deat	g. No. 200	3. Time of Death
Physic edical Exam		ROMIE		-	ZIEGL	.ER		Month June 22, 2	Day Year	2101 hrs
9		4a. Facility Name (if not institution, g University Hospital	give street and nu	mber)		City, Town, or Baltimore	Location of D	Death	4c. County of Dea	th V/A
Funeral			Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Yea	ar If Under 2	4Hrs. 8. Date of Birt		irthplace (State or
Director		213-15-0983 1	X M 2 F		2/ Yrs.	Months Day	s Hours	Min. MARCH	24,1987 Fore	eountry)MARVLAND
ž.		Usual Residence of Decedent 10a. State 10b, County		Inc. City	Town or Location				,	10d. Inside City Limits
Maryland 28a-f show any d at once.	5	MARYLAND ^	JIA	Too. Oily,	TOWN OF ECOCIO	BA	LTIMO		ITV	1 X Yes 2 No
Baltimore, MD 21215-0036 permit Pages I and 3 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene observants in Firens 23a or 28a-f sho important: If titen 273 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	Tail Da	04 ==	20405	Of. Zip Code	211	5 1 2	og. Citizen of What Co	untry?
eath with th items 23a ust be notil	la l	11. Mantal Status	12. Was Dec	edent Ever in U.	S. 13. Was I	Decedent of Hi	spanic Origin?	(Specify Yes or No-	14. Race - Ame	erican Indian, Black,
r death or item must b	uneral	1 Never Married 2 Marri	1 Yes	2 No	If Yes	, specify Cuba	n, M exican, Pu	uerto Rican, etc.)	White, etc.	
s after iral", o	by F	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ed If Yes, Give Year or Dates:		1 Y	es 2 No		d of work done	Specify: 16b. Kind of Business	LACK
72 hour	Completed	Elementary/Secondary (0-12)	College (1			t of working life			Tob. Kind of business	S/III OUS II y
5-0036 led within 7 Hygiene. I other than	直	12 +HGRADE			Ha	ODE	PT		CITYO	F BALTIMORE
21215-0036 hould be filed within 72 hours after on Mental Hygienes is marked other than "matural", tite event, the Medical Examiner.		17. Father's Name (First, Middle, La	ist)	7150	150		18.Mother's N	Name (First, Middle, N	Maiden Surname)	0.04
2121 ould be fi Mental marked c event,	o Be	19a. Informant's Name/Relationship	(Type, Print)	<u> 21EG</u>	19b. Mailing A	ddress (Stre	et and Numbe	r or Rural Route Num	ber, City or Town, Sta	te, Zip Code)
Baltimore, MD 21215-00: pemit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other it migury or other traumatic event, the Med		MONIQUE BLAI	KE (M	OTHER) 2812	2 CLII	-TON F	ARK TERRI	ACE BALK	0, MD21213
ore, ME ss 1 and 2 s of Health an If item 27 her trauma		20a. Method of Disposition 1 Durial 2 Cremation	3 Removal fro		Place of Disposition of Place of Disposition of Place of Disposition of Place of Pla		emetery,	Date	20c. Location - City	or Town, State
Baltimore, Dermit. Pages lar Department of Hes Important: If ite	- 5	4 Donation 5 Other Spec		M	T. ZION	CEME	ERY 0	6-27-08	LANSDO	WNE, MD
Balti permit. Departm Imports		21 SI Maldre of Pulleral Service Lib	1/11/1	Man	J. J.	ne and Addres	HEIT	BROWN !	BAITA N	NAL 1011E
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on		aused the death	. Do not enter the	mode of dying	, such as card	liac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner			a. Gunshot W							Death
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence o	f):					
B 8 4	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	f):					
be executed ician and urial - transit	dical	UNPENDED	dAMENDED							
	Med	IF FEMALE:	23c. If yes,	outcome of preg	nancy				23d. Date of delive	•
Box 68760 e death certificate I the attending phys	sician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live b	irth ant at time of de	oth	death 3 r (Specify)	Ectopic pr	regnancy	Month	Day Year
BO) e death the att	Physi	1 Yes 2 No 9 Unkno	9 Olikiic							
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate livition 24 hours after death. To the Funcato Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the by	5	Part II. Other significant condition	s contributing to	death but not re	esulting in the und	lerlying cause	given in Part I		obacco use contribute 2 ✓ No 3 Pr	obably 4 Unknown
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of Vi Physicer this	은	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 🗸 I		ER/Outpatient 28b. Time of Inju		ury at Work?		Residence 6 Oth	ner:
ON C ending ath. or: Aft	tion	1 Natural 5 Pending	Jun 22,	Day Year) 2008	2031 hrs	· ·	Yes 2 ✓ No	Cubicat abo		
Division of Vital Records, P.C. spiral or Attending Physician: The law requires that ours after death. retal Director: After this certificate has been signed filled in by the funeral director, page 2 should be dete	ertification:	2 Accident Investig 3 Suicide 6 Could n	ot be 28e. Place		ome, farm, street,	factory, office	building, etc.	28f. Location (S or Town, S	Street and Number or litate) reet , Baltimore , M	Rural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	0	4 Homicide determine 29a. Certifier 1 Certifying Physics	(0,000.1)	Sidewalk	ne death occurre	d at the time d	late and place		reet , Baltimore , M e(s) and manner as st	
To the Hos within 24 h To the Fun completely	Medical			of examination a					and place, and due to	
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		tate liner	uca -t	Oller	MD	0.0	.M.E.		June 23, 2008	
2		30. Name and address of person when Patricia Aronica-Pollak M		se of death (Item ant Medical I		11 Penn S	treet, Balti	more, MD 2120	1	
S		31. Date filed (Month, Day, Year)	447	gistrar's Signatu	ıre				-	
Regis	trar	JUN 2 6 200	8 100	Se-	A 00					

DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 445 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Himo. 0 UniversiT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8 5. Social Security Number 6. Sex Birthplace (State or Foreign Country)
 TTT 7. Age (In vrs. last birthday **Funeral** Days 1**X** M 2□ F Months Hours Min. 70 104-30-3382 NYDirector Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified or once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD Frederick Monrovia Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4429 Greenvalley Rd P.O. Box 48 217701 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Arianna Zanchelli ္ပ Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 7 7 0 19a. Informant's Name/Relationship (Type. Print) Sarah Arianna Wife 4429 Greenvalley Rd PO Box 48 Monrovia, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison For Vet. 6-25-2008 Owingsmills, MD 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service kicensee M01176 106 East Church St. Frederick, MD 21701 ty. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carding or respiratory arrest, k, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** aronaro /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 \sum No certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient 3 DOA Certification: To 2 ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury within 24 hours arter vec...

To the Funeral Director: Aft investigation Μ 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 6 2008

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. Registrar's Signature

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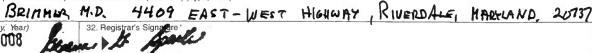
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29b. Signature and title of certifier

ALLEN

29a. Certifier

Medical



and manner stated.

H. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

Registrar

29c. License number

D- 25914

29d. Date signed (Month, Day, Year)

6-9-2008

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 8'50 PM ZOUS Etrain /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Manyland Medical Center Baltmore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 45 yrs. 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F Months Days Hours Min Director 220-31-0104 Aug. 13, 1962 El Salvador Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show be notified at Md. Anne Arundel Lothian 1 ☑ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or important: If Item 27 is marked other than "natural" or items 29 or more. 4965 Solomons Island Road 20711 El Salvador Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Salvadoran Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manager Highland Landscape 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jose Sabino Andino Maria de Jesus Portillo 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose C. Andino (Brother) 4965 Solomons Island Rd. Lothian, Md. 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/16/2008 Family Cemetery El Salvador 4 Donation 5 Other (Specify) 21. Signature of/Funeral S∉vice Licensee W. H. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, D.C. 20010 23a. Part1. Enter the disease, or complications that caulled the death. In not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebal Anexica **Physician** /Medical Due to (or as a consequence of) **Examiner** Brain Traumate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the bunal-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy ned by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 2 □ No or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 8 39 PM 1 Yes 2 No -2-2008 to-11 2 Accident down steps within 24 hours after death To the Funeral Director: 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1917 Ridgeville Ku Edgewater, MD 20711 home To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore MD 31. Date filed (Month, Day, Year) 5 Greens 32. Registrar's Signature State JUN 1 2 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2:45PM M Phyllis A. Anderson 2008 June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9500 Thornknoll Court Prince George's Fort Washington Year If Under 24 Hrs. Days Hours Min. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days 290-30-6865 71 9/20/1936 Toledo, Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 9500 Thornknoll Court United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bank Adminstration <u>Private</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew G. Harris Avonia Rucker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Anderson / Daughter 7213 Wood Hollow Terr. Fort Washington, Md. 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 6/16/2008 Cheltenham, Maryland Maryland Veterans 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 wests Due to (or as a nsequence of): Due to (or as nsequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Examiner

Physician/Medical

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Certification:

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Pages 1 Important; If II any Injury or

Baltimore, Maryland 21215-0036

ng physician and as the burial-transit signed by the attending I has page 2: certificate funeral death. nours after death neral Director; / filled in by the f

The law requires that the death certificate be executed

O. Box 68760,

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Records,

of Vital

Division

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Ave. #18 Upper Map/bako,

Within 2

Hospital or Attending Physician;

24 hours a

etely

State Registrar 31. Date filed (Month, Day, Year) JUN 1 2 2008

9450 Funn. laucean 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TALBOT I Social Security N 213-44-1 Sual Residence of Da. State MD De. Street and Nur 300 LEM I. Marital Status I Never Marr 3 XWidowed (Spec Elementary/Seco 12 7. Father's Name RUSSEL 9a. Informant's N	HOSPICE Jumber 6 053 F Decedent 10b. County WICO Tied 2 Married 4 Divorced 15. Decedent's city only highest condary (0-12)	TKEN pive street and number) HOUSE Sex 1 M 2 AF 7. Age To Make the street and number of the	SA Ever in U.S.	yrs. If U Mo	Under 1 Year On Days Days Of Zip Code 2180 Decedent of His, specify Cuba			, Year) , 193	7 MAI	thplace (State or Fore puntry) 10d. Inside City Lim 1XIYes 2 1	
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RUSSEL 9a. Informant's Na	•			HOME	EMAKER						
9a. Informant's Na	LL W. DAY	•				18. Mother's Nam	RETTA RE		<i>Surname)</i>		
			10	9h Mailing Ad	dress (Street	and Number or Ru			r Town State	Zin Cade)	
T ADECA E				-				-			
		BON, IROBIEL	20b. Place	of Disposition	n (Name of	i					
			4/2008	TILO	HMAN,	MARYLAND					
			X I II O	On No.	ma and Addres	on of English					
Joseph	m. Os	trowski C.F.	5.P.	200	S. HAR	RISON_ST	EASTC	N, N	D 2160	1	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									Interval Between Onset and Death Days Month		
3b. Was deceden in the past 12 1 ☐ Yes 2 [nonths? ☐ No	1 ☐ Live birth	2 Fetal dea			1		2	23d. Date of de Month	elivery Day Year	
art II. Other signi	ificant condition	s contributing to death bu	ut not resulting	g in the underl	lying cause giv	en in Part I.				o the cause of death?	
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examiner?		Hospital:			Oth	er.					
		1 inpatie			BU DOA	4 LI Nursing H				ecify) HOSPIC	
1 Natural	5 Pending	(Month, Day		Injury			200. 20001120 1	ion injui	y 000anoa		
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no	t be 28e. Place of inju	ury - At home, c. (Specify)	farm, street,						ìural Route Number,	
9a. Certifier (Check only one)		xaminer: On the basis of	examination :								
9b. Signature and	d title of certifier		A 8	_							
▶ Lab	hun Va	idyanathan	n M			57740		IUN	E 9,	2008	
	•					Q71 17 A C	ጥርክ Μኮ	214	0 1		
						or., LAS	LUM, FID	210	<u> </u>		
	Da. Method of Dis 1 Burial 2 4 Donation 23 Part1. Entershock, or her mediate Cause sisease or condition esulting in death) Gequentially list color any, leading to rause. Enter Undiause. Enter Undiause. Enter Undiause (Disease on hat initiated event esulting in death) F FEMALE: 3b. Was deceder in the past 12 1 Yes 2 9 Unknown art II. Other signification of Death	23a. Part1. Enter the disease, or or shock, or heart failure. List or mediate Cause (Final disease) or condition esulting in death) 25a. Part1. Enter the disease, or or shock, or heart failure. List or mediate Cause (Final disease) or condition esulting in death) 25a. Part1. Enter the disease, or or shock, or heart failure. List or mediate Cause (Final disease) or condition esulting in death) 25a. Part1. Enter the disease, or or shock, or heart failure. List or mediate cause. Enter Underlying cause (Disease or injury hat initiated events esulting in death) Last 25b. Was decedent pregnant in the past 12 months? 25c. Was case referred to medical examiner? 26c. Was case referred to medical examiner? 26c. Was case referred to medical examiner.	A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1. Signature of Funeral Service Licensee 1. Signature of Conditions on Conditions that caused shock, or heart failure. List only one cause on each ling and the cause of Conditions on East o	Da. Method of Disposition Second Comment Comment	Da. Method of Disposition Da. Method of Disposition 20b. Place of Disposition 2	Da. Method of Disposition 1	Doa Method of Disposition 1	Date Da	Date Date	Date Da	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 () () 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month 2008 7:45 pm Ethel Mason Barbee Tune 8, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Prince Georges 3420 Rickey Ave. #244 Temple Hills If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🙀 F Director 578-09-7384 Tune 7, 97 1911 Be1 Alton, Md. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show unt: If the the traumatic event, If "Murdical Evanting or Jun 19 or other traumatic event, If "Murdical Evanting or Jun 19 or other traumatic event, If "Murdical Evanting or Jun 19 or other traumatic event, If "Murdical Evanting or Jun 19 or other traumatic event, If "Murdical Evanting or other traumatic event, If "Murdica 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Evaminer must be notified at Director 1 TxYes 2 □ No Maryland Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3420 Rickey Ave #244 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2√☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Mason ပ Lula Proctor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burma S. Hill / Niece 9201 Gary La. Springdale, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) 6/13/2008 Silver Spring, Md. 22. Name and Address of Facility
Alexander S. Pope P.A.
5538 Mariboro Pike/Forestville, Md. 21. Signa of Funeral Service Licer MOIDS 20747 23a. Part 1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (chas a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): ng physician as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an this certificate has I page 2 1 ☐ Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5€ Residence 6 ☐ Other (Specify) Hospital: 1∐Yes 2√2No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation iours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29b Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, 32. Registrar's Signatu

name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 18, 2008 1:02 PM June William Taylor Bryant, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 67 9-20-1940 Washington, DC Director 577-54-1988 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director MD St. Mary's Mechanicsville 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20659 27691 Valley Wood Ct. United States Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: 2 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than Carpenter Carpentry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi is marked Taylor Jennings Bryant Mary Blanche Bryant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other tra 27691 Valley Wood Ct., Mechanicsville, MD 20659 Diane Bryant (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 6-23-2008 Clinton, Maryland 22. Name and Address of Facility Brinsfield-Echols Funeral Home 21. Signature of Funeral Service Licensee Danie Me Ward 1403 30195 Three Notch Road, Charlotte Hall, MD 20622 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final WTERCEREBRAC **Physician** disease or condition resulting in death) 41NUTES /Medical Due to (or as a consequence of): Examiner Pertenson Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital/Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1∏ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🔲 Yes 1 Inpatient 2 XER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manger of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury Natural within 24 hours aren
To the Funeral Director: Aft 1 ☐ Yes 2 □ No 2 Accident 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29b. Signature and title

State

JIC-14M

Registrar DHMH 17 Rev 1/2001 30. Name and addre

31. Date filed (Month

of person who completed cause of death (Item 23a) (Type, Print)

KARL SYOBODA

70062937

2600 POWILOOKOVI ROAD, LEONANDTOWN, MD

death with the Maryland Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Ite

BONNIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			For State	State of Marylan	d / Department o <i>Certificate d</i>				
			State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate C	Dealli	Reg. 2. Date of Death	N°2008	20766 3. Time of Death
100	Physici /Medic		Leon	Pershina	Barb	our.		Day 2008	0935 AM
Y	Examin		4a. Facility Name (If not institution, give s	treet and number)		n, or Location of Death		4c. County of Deat	th
		80	Holy Cross Hosp			Spring		Montgo	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. M 2 F	last birthday) If Under 1 Yes. Months Da	ear If Under 24 Hrs. ys Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Co	thplace (State or Foreign buntry)
£2.	Director		242-38-9039 Usual Residence of Decedent	89	115.		April 6,	1919 No	orth Carolina
	land ow it		10a. State 10b. County	10c. Cit	y, Town or Location	· · ·			10d. Inside City Limits
	Mary -f she iied a	ξ	Maryland Montg	omerv	Silver Spring	т			1 □Yes 2√√No
	r 28a	Director	10e. Street and Number	Jilely	10f. Zip Coo		10g.	. Citizen of What Co	ountry?
	h with		10314 Calumet Dr	ive	2	20901		USA	
	ems (Funeral	11. Marital Status	Was Decedent Ever in U Armed Forces?	.S. 13. Was Decedent If Yes, specify	of Hispanic Origin? (Spe Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married	1XX es 2 No If Yes, Give	nown 1□Yes 2th			Specify: W	Mite
21215-0036	hours tural? al Ex	d b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ		16a. Decedent's Usual O	ecupation	16	b. Kind of Business/	/Industry
5	in 72 i "na" ledic	Completed	(Specify only highest grade	completed)	(Give kind of work do life. DO NOT use re	one during most of working tired)	ng		,
72	within jiene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Tile Sette	er		Governme	ent
שַ	e filed al Hygi other vent, tl	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Mai	iden Surname)	
<u>Jar</u>	ould be Mental arked o atic eve	TO E	William R. Barbo	ır		Nellie	Johnson		
Maryland	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailing Address (Sta	reet and Number or Rura	ıl Route Number, C	ity or Town, State, 2	Zip Code)
	1 and 2 Health em 27 i		Kenneth Lee Barbo	ır/Son	10400 Calumet	Drive, Sil	ver Spri	ng, MD 20 c. Location - City or	901
altimore,	6 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation : 3 ☐ Re		Place of Disposition (Name of cemetery, crematory or other		ine 11,	2. Location - City or	Town, State
ij.	tmen tant:		4 □ Dopation 5 □ Other (Specify)	4 2	tropolitan Cr	! -	2008		ia, Virginia
Bai	permit. Page Department of Important: If any injury of once.		21. Signature (Funeral) Stry & Licen e	Magnes		J. Collins			
			22a Part1 Enter the disease or compli	cations that caused the deal					ng, MD 20901 Approximate
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	201101 01101 1110 1110 11	a,g,		,	Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	Respiratory Due to (or as a consequence)					
	Examiner			Aspiration					
		ē	Sequentially list conditions, it any leading to immediate	Due to (or as a consec					
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68760,	ficate be executed physician and s the burial-transit	edical	d				·		
_		Med	IF FEMALE:		-				
Вох	The law requires that the death certifithe has been signed by the attending tage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregn 1☐Live birth 2☐Feta	al death 3 □Ectopic pregr			23d. Date of de Month	elivery Day Year
	at the dea by the a tached for	/sic	1 Yes 2 No	4□Pregnant at time of one of the state of t	death 5 ☐ Other (specif	y)			
P.0	that the ed by detac		Part II. Other significant conditions cor	tributing to death but not res	sulting in the underlying cause	e given in Part I.	23e. Did tobac	cco use contribute t	to the cause of death?
or Vital Records,	signe d be	d by	Cardiomyopathy,]	Jon-Sustained	Ventricular	Tachycardia	1 ☐ Yes	2 No 3 P	robably 4 🔀 nknown
20.	w requir been si should I	Completed					24a. Was an	24h. Were a	utopsy findings available
Re	has ge 2	臣					autopsy performe	prior to death?	completion of cause of
ā			25. Was case referred to medical			26 Place of Deat	1 Yes 2 1 (Check only one)	XNo 1LIYes	s 2□No
₹	Physician: r this certifica ral director, l	To Be	evaminer?	lospital: 1 X Inpatient 2	ER/Outpatient 3 □ DOA	Other:		ce 6 □Other (Spe	ecify)
0	g Phy erthi		27. Manner of Death	28a. Date of Injury (Month, Day Year)			28d. Describe how		
Ö	Attending F r death. ector: After by the funer	atio	1 Accident 5 Pending investigation	(World), Day Tear)	М	1 ☐ Yes 2 ☐ No			
Division	r Attend er death. rector: / by the f	E E	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	nome, farm, street, factory, of	fice	28f. Location (Stre City or Town,	et and Number or Fl State)	Rural Route Number,
	ital o	Certification:							
	Hosp 4 hou Fune tely fil	ical	(Check only 2 Medical Exami	ner: On the basis of examin	owledge, death occurred at t ation and/or investigation, in	he time, date and place, my opinion, death occur	and due to the cau red at the time, dat	se(s) and manner a e and place, and du	as stated. ue to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. Li	cense number	290	d. Date signed (Mon	nth, Day, Year)
	→ × × × × × × × × × × × × × × × × × × ×		> Sinftra	M·S		D64100		-	.0, 2008
	7		30. Name and address of person who or						
	1		30 Name and address of person who co Smitha Bhikkaji, I	1D 1500 For	est Glen Road	l, Silver Sp	oring, MD	20910	
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature				
	Regist		JUN 122008	Be was L	t species				

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			For State Registrar		State of	t Marylar		artment of l artificate of		Mental Hy				-
				ne (First, Middle, Las	st)			Timeate of	Death	2. Date of D	eath	2008	3. Time of De	6/
	Physicia		Robe	rt Ernes	st Banl	kard				Month 6	-09.	y Year	30	PM
	/Medic Examin		4a. Facility Name (If not institution, give	e street and nur	nber)		4b. City, Town,	or Location of Dea	th	4c.	County of Dea	th	
		12		l Hospit					inster			Carrol		
	Funeral Director	C I A V	5. Social Security N 220-03-	1	ex M 2□F	7. Age (In yrs. 86	last birthday Yrs.	Months Days			ay, Year) 1 / 192	21 MD	thplace (State or Fountry)	-oreign
3	N		Usual Residence o	10b. County		10c. Ci	ty, Town or L	ocation					10d. Inside City	Limits
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	atura ical E		/Sno	15. Decedent's Ed		,,,,,,	16a. Dece	edent's Usual Occu	pation	orkina	16b. K	ind of Business	/Industry	
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7	tygier her th			(First, Middle, Last,	1		Far	mer	19 Mother's N	ame (First, Middi		ricult	ure	
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, war	permit. Tages I and a Should be liled within 72 hours after death with the wadylar begardering to Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.			Name/Relationship (riend	19b. Maii 1193	ing Address (Stree B Long V	tand Number or I	Rural Route Nurr Rd. Wes	stmir	or Town, State, nster,	MD 211	58
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	portal	21. Signature of Funeral Service Licensee MO1191 22. Name and Address of Facility Myers-Durboraw Funeral Home, P.									.A.			
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ij	3		shock, or hea		one cause on e	aused the dea ach line.	th, Do not er	nter the mode of dy	ing, such as cardi	ac or respiratory	arrest,		Approximate Interval Betwe Onset and De	een eath
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5	r this ral dir	. To	1 ☐ Yes 2 27. Manner of Dea	No	28a. Date		ER/Outpation 28b. Time	of 28c. Inju	4 ∐ Nursing urv at	Home 5 ☐ Re			ecify)	
	naing th. r: Afte e fune	ation	1 Natural 2 Accident	5 ☐ Pending investigation	(Mon	th, Day Year)	Injury	Wo	ork?]Yes 2∐No		•	•		
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	To the pospiral or Authening Priystolan. The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	Medical Ce	29a. Certifier (Check only one)	1 Certifying Ph	miner: On the b	asis of examin		ath occurred at the investigation, in my						
25. Was case referred to medical examiner? 1						nth, Day, Year)								
F	111		1	Jan				D	3026	3	6	-09-	08	
	WIVA		30. Name and add	dress of person who	completed caus	se of death (Ite	m 23a) (Type	e, Print)			l		erro 1	1D
6	-11-		FRA	VUS KI	100 N	ID 2	ao m	Embria	LAVE	-NUE V	VES	TMIN	2115	7
	Sta Registr		31. Date filed (Mo	nth, Day, Year) JUN 1 1	2008	legetrar's Sign	ature	house					/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 une JW0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Baltimore City** Daltimore The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🗙 F Days Hours Min 215-44-7292 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 □ No Director "intland Icomico 11 10g. Citizen of What Country? 10e. Street and Number ò r items 23a or 21826 202 Funeral SA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. ģ Specify: 3 Widowed 4 □ Divorced Black "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical I 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Wh 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a lyrone permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other Injury or other Date 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c/Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -08 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 Street W. Isabella. ouce Mary Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, shock, or heart failure. L complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final **Physician** PS.DIra Stress drom minutes disease or condition resulting in death) /Medical nce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death)! Examine Due to (or as a consequence of) The law requires that the death certificate be executed y physician and as the burial-trant Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as attending | IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No ate has been signed by the an page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?... Yes 2.2.No 2 □ No 1 Yes or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 4 \square Nursing Home 5 \square Residence 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Cher (Specify) ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 008

State

OCA D CKect MD MV
31. Date filed (Mpath Pay Year) 2008 Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

Name and address of person who

Registrar

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:10P M Jun 20, 2008 Rose M. Cartwright /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 256 Blackiston Avenue Cumberland Allegany If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2□F Director 574-52-8095 Apr 11. 1958 ÓΚ 50 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or items 200 mental any Injury or other trainmain. 10c. City, Town or Location 10h County 10d. Inside City Limits MD Allegany Cumberland 1 ¥Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 256 Blackiston Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Xo Specify. Specify: Completed by 3 ☐ Widowed 4 X Divorced Year or Dates: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dietary Department Thomas B. Finan Ctr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Fitzpatrick Nettie Fitzpatrick 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 256 Blackiston Avenue Autumn Cartwright daughter Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ X remation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 6/22/2008 MD Cresaptown 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a Fart1. Enter the disease of complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTANC ENDOMETRIAL /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to find eductions. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualty for as a consequence of Examiner been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29c. License number 29b. Signature and title of certifier D60478. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 904 SETON DR. CUMBERUND, MD 21503 AHMAD, M.D. AFAQ 32. Registrar's Signature 31. Date filed (Month, Day, JUN 2 6 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Dav **Physician** 1:15 p M Thomas P. W. Cheung 2008 June 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4028 Evangeline Terrace 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠** M 2□ F Director 220-88-9823 85 China November 7, 1922 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4028 Evangeline Terrace 20832 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 □ Never Married 2 x Married 1 ☐ Yes 2 🗷 No Specify. Completed by Specify 3 ☐ Widowed 4 ☐ Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Owner** Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 S. P. Cheung C. H. Yeung 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17213 Wellfleet Drive, Olney, Maryland Peter Y. Cheung - Son 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 06/13/2008 Silver Spring, Maryland Signature of Funeral Selvine Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Immediate Cause (Final **Physician** disease or condition resulting in death) Gastric Hemorrhage 2 days /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus 20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-trar Chronic Renal Failure 10 years Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No page 2 autopsy performed? 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 R No 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HYSICIAN D43869 June 11, 2008

Registrar

State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

Nelson Lui, M.D., 11908 Darnestown Road, Suite D, N. Potomac, Maryland 20878

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 9,2008 Margaret Carroll 4:30p M M. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill Nursing Home Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1918 Sirthplace (State or Fo 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 1 F Months Days Min. 104-03-9953 89 Hours Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Bethesda 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9617 Weathered Court 20817 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: White 3₺ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Thomas Heslin Delia Quinn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Carroll/Son 9617 Weathered Court Bethesda, Md 20817 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriat 2 ☐ Cremation 3 Removat from State St.John's Cemetery 6/13/2008 Trenton, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) PATTITY ADERTMALDI FUNERAL SERVICE, P.A. Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA disease or condition resulting in death) Due to (or as a consequence of): BSTRUCTIVE PULLENARY HRONIC Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARKINSONS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 **№**No 2 DNo 1 □ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending investigation 21 Accident

Box 68760, P.0. Division of Vital Records,

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran s been signed by the should be detached certificate has page 2 director, After this funeral ours after death.
neral Director: A To the Hospital within 24 hours a To the Funeral I Hospital

Physician

/Medical

Examiner

Funeral

Director

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Completed

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d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exaction or must be profitted at

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev

Physician

/Medical

Examiner

Examiner

Physician/Medical

Be

Certification: To

Medical

State

Registrar

Baltimore, Maryland 21215-0036

Completed by 25. Was case referred to medical examiner?

3 ☐ Suicide

(Check only one)

29a. Certifier

6 ☐ Could not be determined 4 Homicide

and manner stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D0057124 29d. Date signed (Month, Day, Year) 6/10/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9715 Medical Center Dr. #201 Rockville, Md 20850 Truong Bao MD

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 2 2008 JUN



08-04487

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Marviano /	Department of Featur	aria monta	

2008 20772

INK		State of Maryland / Department of the cor State of Maryland / Department of the cor State	eath	Reg. No.		
Physician	1.	gistrar Decedent's Name (First, Middle,Last)	F - 1	2. Date of Death Month Day June 11, 2008	Year 3. Time of Deat 0002 hrs	th
cal Examine	r	ANDREW C. COXSON Facility Name (if not institution, give street and number) 4b. (City, Town, or Location of Death	40	County of Death	
	4a	18104 Croom Road	randywine		Prince George's	r Forein
Funeral	5.	Social Security Number 6. Sex 7. Age (111)13. Tust Small Security	Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (MM APRIL 29	/DD/YYYY) 9. Birthplace (State of Country)	
Director	1	064-64-7246 1X _M 2F 38 Yrs.		AFRIL 27		
any	_	sual Residence of Decedent a. State 10b. County 10c. City, Town or Location			10d. Inside Cit	
≹ .₁	5	MD Prince George's HUGHVILLE	Bowie	10g Gi	tizen of What Country?	
Maryland 28a-f show d at once.		De. Street and Number 15512 Powell Lane	20716	, og. s.	USA	
		16902 TIDEWATER LANE 1. Marital Status 12. Was Decedent Ever in U.S. 13. Was In 1990 1990 1990 1990 1990 1990 1990 199	ecedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian, Bla White, etc.	ick,
eath w	<u> </u>	X Never Married 2 Married 1 Yes 2 X No	specify Cuban, Mexican, Puerto	Ricari, etc.)		
after d	: [Wildowed 4 Divolced or Dates:	es 2 X No specify: Usual Occupation (Give kind of v		Specify: BLACK Kind of Business/Industry	
led within 72 hours after Hygiene. other than "natural", the Medical Examiner	eted	15. Decedent's Education (Specify only highest grade Completed) Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use reti	red)		
thin 72 ne. than ledical	립	4 yrs CORREC	TIONAL OFFICER	G (First, Middle, Maide	OVERNMENT en Surname)	
Hygie d other		7. Father's Name (First, Middle, Last) ANDREW COXSON SR.	PEN	NNY PORT	ER	
Id be Aenta narke	സി	99. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street and Number or			007
S S S S		BETHERETT COLOR	STLEWOOD PLACE	UPPER MAR	LBORO, MARYLAND c. Location - City or Town, State	207
es l and 2 s of Health ar If item 27		crematory or othe	r place)	16/2009	TIDDERACKVILLE N	IV
Dalullore; permit. Pages I a Department of He Important: If its injury or other t	- 1	KUKAL VALI	me and Address of Facility	J. B. JENK	CUDDEBACKVILLE, N	ΙE
Depar Depar Impor	- 1		4 LANDOVER ROAL	D LANDOVER	shock or heart Approxima	
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arrest,	Between C	
'Medical aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
	- 1	b.				
		if any, leading to immediate Due to (or as a consequence or).				
Ţ	ĒΙ	(C)sease or injury that initiated events resulting in death) Last				
50, te be executed sysician and burial - transit		d. UNPENDED X AMENDED 10b,c,e,f per	inf g885 11-13	3-08 vt		
50, te be ev sysiciar burial	Medic	IF FFMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery Month Day	Year
tal Records, P.O. Box 68760, inst. The law requires that the death certificate be certificate has been signed by the attending physic ector, page 2 should be detached for use as the but	Physician/Medical	23b. Was decedent pregnant in the 1 Live birth 2 Fet	al death 3 Ectopic preg	nancy	Month Bay	
SOX leath o	ysic	1 Yes 2 No 9 Unknown 9 Unknown		Laza Did toba	cco use contribute to the cause of	f death?
<u> </u>		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		2 ✓ No 3 Probably 4	
S, P.O. uires that the name of the signed by Id be detac	ed by			24a. Was an		gs avai
ord: aw requas been as been 2 shoul	Completed			autopsy perform 1 ✓ Yes 2	ed? death?	
Rec The life at the page	Con		26.Place of Death (Che	12.0		
Vital Rec ysician: The l his certificate l director, page	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient			esidence 6 Other: Scene	
n of Vital Records, ding Physician: The law requin . After this certificate has been s funeral director, page 2 should	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of (Mogth Day) (Mogth Day) (Mogth Day)	njury 28c. Injury at Work? 1 Yes 2 ✓ No	Driver auto fix	w injury occurred ked object collision	
ision Attendii r death.	atio	1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, stre		28f. Location (St	reet and Number or Rural Route N	Number,
Division Isl or Attendii rs after death. al Director: /	Certification:	Suicide 6 Could not be determined (Specify) Local Street			Road, Brandywine, MD	
Division of Vital Records, P.C To the Hospital or Attending Physician: The law requires that within 24 thours after death. To the Funeral Director: After this certificate has been signed I completely filled in by the funeral director, page 2 should be deta		4 Homicide	rred at the time, date and place,	and due to the cause	(s) and manner as stated. nd place, and due to the cause(s)	
o the I ithin 2 o the F	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	tion, in my opinion, death occurre	ed at the time, date a	29d. Date signed (Month, Day, Ye	ear)
F 3 F 8	ž	29b. Signature and title of certifier	O.C.M.E.		June 11, 2008	
	1	30. Name and address of person who completed cause of death (Item 23a)				
(5)		Tasha Greenberg MD. Assistant Medical Examiner 111	Penn Street, Baltimore,	MD 21201		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 20773 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Waldon Frank 8:30 Р м Crissey June 8, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent Center Crofton Anne Arundel 6. Sex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days Year) 1 ₩ M 2 🗆 F 192123709 83 Director July 1924 Pa Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Virginia Prince William Director Dumfries 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, Item Modical Examinations to mast be many Injury or other traumatic event, Item Modical Examinations. 15608 Northgate Drive 22025 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 MYes 2 No 1943 If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Writer Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jackson R. Crissey Jennie Frank 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Crissey (Wife) 15608 Northgate Drive, Dumfries, VA 22025 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date THE Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery June 14,2008 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral cu 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandira Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Obstructive MONIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequent law requires that the death certificate be executed Cance attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ş 2V No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate Division of Vital 1 ☐Yes 1 ☐Yes 2 ☐No 2 No Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 2 No Hospital: Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home After this 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 1 Zi Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation ours after death.

eral Director; Af
filled in by the fur 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora, M.D. 14300 Gallant Fox Lane Suite 222, Bowie, MD 20715

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

32. Registrar's Signature JUN 1 2 2008

and manner stated.

Registrar

MI

20108

29d, Date signed (Month, Day, Year)

		For State Registrar	State of Ma	ryland / De _l	partment of I ertificate of	lealth and Death	Mental Hy	rgiene 20	008 20	77
Physici /Medic	cal		Ē	Danne	T	and a set Dook	2. Date of Do Month 06	18 2	Year 008 073	
Examir	ier	4a. Facility Name (If not institution, give MEMORIAL HOSPITA 5. Social Security Number 6. Se	L	(In yrs. last birthda	CUMBE		. 8. Date of Bi	rth	GANY 9. Birthplace (State	or Foreign
Director			7M 2□F	81 Yrs.	Months Days	Hours Min.	(Month. D	ay, Year) 6, 1926	Country) MD	————
e Maryland a-f show iffied at	ctor	MD 10b. County Allega		10c. City, Town or Spi	ring Gap		_		10d. Inside 0	City Limits
th with the 23a or 28 Ist be not	al Director	10e. Street and Number P.O. Box 38			10f. Zip Code	21560		10g. Citizen of V	What Country?	
5-0036 72 hours after death with the Maryland natural", or Items 23a or 28a-f show lical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	ver in U.S.	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No		Specify Yes or Noto Rican, etc.)	o- 14. Race Blac Specify	e - American Indian, k, White, etc.	
	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+	(Gir	cedent's Usual Occup ve kind of work done . DO NOT use retire	pation during most of wo ed)	rking	16b. Kind of Bu	nburg Cent	ter
ire, Maryland 212' s 1 and 2 should be filed withir if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M	To Be (17. Father's Name (First, Middle, Last) Lester Mullena)	‹				•	er Mullena er Mullena	,	
re, Mary 1 and 2 sho 1 Health and tem 27 Is m		19a. Informant's Name/Relationship (7) Gail Ritchie	^{/pe. Print)} daug	hter P.	O. Box 22			ng Gap	State, Zip Code) MD 215	60
Baltimore, permit. Pages 1 ar Department of Hea mportant: If item any injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 6 ☐ Other (Specify)			position (Name of rematory or other pla morial Park	ice)	Date 6/22/2008	20c. Location -	City or Town, State	MD
Baltimol permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Icons	1		22. Name and Addre Scarpe 108 Vir	ss of Facility Illi Funeral Ho ginia Avenue	ome, PA	and MD 215	02	
Physician /Medical Examiner	Examiner	23 Fart1. Filer the disease, or comp shock, or heart frilure. List only o Immediate Lause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	miler the mode of dyi	ng, such as cardia	c or respiratory a	arrest,	Approxima Interval Be Onset and	etween
.O. Box 68760,74, the death certificate be executed by the attending physician and tothed for use as the burial-transit	Physician/Medical Ex	i i i i i i i i i i i i i i i i i i i	Due to (or as a d	Fetal death 3	B⊟Ectopic pregnanc	у		23d. Dat Mor	e of delivery nth Day	Year
et e g	þ	Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying cause giv	ven in Part I.			ibute to the cause of 3 ☐ Probably 4 ☐	
Vital Reccicion: The law recertificate has be	Completed						24a. Was auto perfo 1 Yes	psy pormed? c	Vere autopsy findings prior to completion of d leath? □Yes 2□No	available cause of
on or Vita	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		ent 3 DOA Oth	26. Place of Dea ner: 4 ☐ Nursing H		one) idence 6 □Othe	er (Specify)	
Ing Ing After	Certification:	27. Manner of Death 1- Natural 5	28a. Date of Injury (Month, Day) 28e. Place of injury building, etc.	Year) Injury	/ Woi	ryat rk? Yes 2∐No	28f. Location (how injury occurre Street and Number wn, State)	ed er o <i>r Rural Rout</i> e <i>Nur</i>	mber,
Hospita 24 hours Funeral tely filled	Medical Cer	29a. Certifier (Check only one) (Check only one)	sician: To the best of iner: On the basis of e	my knowledge, dea	ath occurred at the ti investigation, in my	me, date and place	and due to the	cause(s) and ma	nner as stated. and due to the cause((s)
To the within 2 To the comple	Mec	29b. Signature and title of certified	and manner state	su.	29c. Licens	se number	,	29d. Date signed	(Month, Day, Year)	>
Sta	te	30. Name and address of person who co SUNIL GUPTA 1 31. Date filed (Month, Day, Year)	1.D (02)	5 Kenr	Print) ANE. C	UMBERU	1 and	UD 215	02	
Registr		JUN 2 6 2008	Belling.	K 40	and I					

		ľ	1- State of Maryland / Department	artment of Health and M rtificate of Death	lental Hy	giene Reg. No. 200	8 20775
F			Decedent's Name (First, Middle, Last)		2. Date of De	eath	3. Time of Death
	Physici		ROBERT MERRELL DAVIS, Jr.		June 7	Day Year	7:00pm M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	oune 7	4c. County of De	
	LXUIIII	٠. ج	9023 GLENARDEN PARKWAY	GLENARDEN		PRINCE	GEORGE'S
21	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Bir (Month, Da	rth 9.B	irthplace (State or Foreign Country)
	Director		189-36-7286 TX M 2 F 59 Yrs.	World's Days Hours Will.	9/29/1		ontown, PA
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	aryla shov	'n					Yes 2 No
	he M 28a-f otifie	Director	Maryland Prince George's Lanham 10e. Street and Number	10f. Zip Code	1	10g. Citizen of What (
	a or						
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show ther the Medical Examiner must be notified at	Funeral	9023 Glenarden Pkwy 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20706 Was Decedent of Hispanic Origin? (Sp		United sta	
	fter d riten iner	Fun	Armed Forces? 1 □ Never Married 2□ Married 1□ Yes 25 No	If Yes, specify Cuban, Mexican, Puerto	Rićan, etc.)	Black, Wh	nite, etc.
5-0036	urs a al"o Exam	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 21 No Specify:		Specify: B	lack
Ō	72 ho natur ical I	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	rina	16b. Kind of Busines	s/Industry
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2	filed wi Hygien ther th	S		ıtcher		Henry's T	owing
<u>n</u>	be fill d oth even	Be	17. Father's Name (First, Middle, Last)	i		e, Maiden Surname)	
Maryland	should be and Mental s marked o umatic eve	은	Robert Merrell Davis Sr.	Marie H			
ā	C1 (0 40 CE			ng Address (Street and Number or Rui			
	1 and 2 Health em 27			Glenarden Pkwy La position (Name of matory or other place)	nnam, M	20c. Location - City of	
و	0 0 4		Taburiai 2 Cremation 3 Removal from State	1	10 000	<u> </u>	•
altimore,	permit. Pag Department Important: any Injury once.		4 □ Donation 5 □ Other (Specify) Fort Line 21. Signature of Funeral Service License 2	2. Name and Address of Facility Pop			d, Maryland
Ba	permit. Pag Department Important: I any Injury o			538 Marlboro Pike			
			23a. Parti. Prier the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician	0 1	Immediate Cause (Final	0		7	Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	none max	-cwc	nico	Josep
g.	Examiner		Correction	mantania			Weekn
	The same	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				1
	cuted nd ransit	Examiner	that initiated events c.	PRUSIATE	CAN	ICEN	Howth
o,	e exe ian ar irial-t	Ë	resulting in death) Last Due to (or as a consequence of):		-		
8760	ficate be executed physician and is the burial-transit	dical	d				
9	entification in graph	Mec	IF FEMALE:				1
. Box	ath c	ian/	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of d	lelivery Day Year
0	ne de the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			,
<u>.</u>	Physician: The law requires that the death certificate has been signed by the attending ir this certificate has been signed by the attending ir director, page 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the u	Inderlying cause given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Vital Records, P.	signe d be	d by			1 🗆	Yes 2D No 3□	Probably 4 Unknown
Š	w require been si should b	Completed			24a. Was	an 24h Were	autopsy findings available
Ä	he lav s has ge 2	du			auto	opsy prior t formed? death	o completion of cause of ?
g	in: Ti ificate or, pa		25. Was case referred to medical	26. Place of Deat	1 Yes		es 2 No
>	Physician: The law this certificate has al director, page 2	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other:		idence 6 ☐Other (S)	aecifu)
Division or	ding Phy h. After this funeral o	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of			how injury occurred	ocony)
0	ath. r: Aft	aţio	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No			
<u>Nis</u>	r Atte er dea recto by th	tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location ((Street and Number or own, State)	Rural Route Number,
Ō	ital or rs after al Di	Certification:					
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier (Check only (Ch				
	the I	Medical	one) and manner stated. 29b. Signature and title of certifier.	29c. License number		29d. Date signed (Mo	nth Day Year)
	N N N		Sold Signature and the			1 1	108
Λ	(10)		20 Name and address of parson who completed gives of Jeath /hom 200 / Time	D31069		0(7/	00
1L	10		30. Name and address of person who completed cause of death (Item 23a) (Type,		2077/		
Ì	Sta	te	George Bone MD 1100 Mercantile Lane 31. Date filed (Month, Day, Year) 32. Registrar's Signature.	Largo, Maryland	20//4		
	Registr		31. Date filed (Month, Day, Year) JUN 1 2 2008 32. Registrar's Signature-				

			1_ State	epartment of Health and N		0 00776
	Physic	ian	Registrar C 1. Decedent's Name (First, Middle, Last) Maria Isabel Domingue		2. Date of Death Month June 9,2008 Yea	3. Time of Death
	/Medi Exami Funeral Director		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital 5. Social Security Number none 1 M 2 F 7. Age (In yrs. last birtho	4b. City, Town, or Location of Death Silver Sprii If Under 1 Year If Under 24 Hrs. Months Pays Hours Min	4c. County of De	eath
26.	P	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	r Location Csville		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 8001 14th Avenue #102	10f. Zip Code 20783	10g. Citizen of What C	-
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☑ Yes 2 ☑ No Specify: E1 Salvado eccedent's Usual Occupation live kind of work done during most of work to DO NOT use retired)	eren Specify:	White ss/Industry
land 21	should be filed wind Mental Hygier s marked other th	To Be Cor	3 17. Father's Name (First, Middle, Last) Juan Vicenti Cruz		e (First, Middle, Maiden Surname) Dominguez	
	and 2 should be lealth and Mental m 27 is marked her traumatic ev			Nailing Address (Street and Number or Rui 11 14th Avenue #		
Baltimore,	permit. Pages 1 Department of He Important: If iten any Injury or oth		1⊠ Burial 2 □ Cremation 3 ☑ Aemoval from State Pueblo	Poloros 6/18,		El Salvado
Ba	permii Depar Impor any In		21. Signatur of Funeral Service Ucensee	PAPETPADOSRINALD 9241 Columbia B	lvd.Silver Spri	CE,P.A. ng,Md20910
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Stage 4 Cervi Due to (or as a consequence of):	cal Cancer	or respiratory arrest,	Approximate Interval Between Onset and Death 1 yr
	Examiner	ner	Sequentially list conditions, if any, Isaamig to immediate cause. Enter Underlying Cause (Disease or injury but listificate and injury but list to be a sequence of the conditions of t	_		6mo.
,8260,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examine	resulting in death) Last C. Due to (or as a consequence of): d. Acute respira			6mo.
.O. Box 6	death certifia e attending p d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of d Month	lelivery Day Year
S, D	The law requires that the de ate has been signed by the a bage 2 should be detached f		Part II. Other significant conditions contributing to death but not resulting in the intractable pain, terminal del		23e. Did tobacco use contribute 1 ☐ Yes 2 ♣No 3 ☐	
tal Reco	ician: The law recertificate has be	Completed by	25. Was case referred to medical		autopsy prior to death? 1□ Yes 2 🕱 No 1 □ Yes	autopsy findings available o completion of cause of ? es all No
Division or Vital Record	Attending Phys r death. ector: After this by the funeral din	Certification: To Be	examiner? 1 Yes 2 Mo 27. Manner of Death 1 Matural 5 Pending investigation 3 Sulcide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	titient 3 DOA Other: 4 Nursing Ho le of ry M 1 Yes 2 No	th Check onl one me 5 ☐ Residence 6 ☐ Other (Sp. 28d. Describe how injury occurred 28f. Location (Street and Number or I City or Town, State)	
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d. 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause(s) and manner rred at the time, date and place, and d	as stated. ue to the cause(s)
-	To the within 2 To the Complete	Me	29b. Signature and title of certifier Barbara Superich RSM, 1		29d. Date signed (Mo.	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	orest Glen Rd. Si	ilver Spring,Mo	20910
DH	Regist		JUN 12 2008 Keepen 15 fg	rante		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician Elvard Robert 06 23 08 1520 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WMHS Memorial Campus Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Reb 15, 1932 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 200-24-9623 Director 76 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits PA **Bedford Bedford** 1 ☐Yes 2☐No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 347 Centreville Road 15522 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 May Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xo Specify Be Completed by Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer DC Metro. Police Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert W. Elvard Ludell R. Davy မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 347 Centreville Road Bedford PA 15522 Shirley Elyard 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Seremation 3 ☐ Removal from State Altoona Area Crematory 6/24/2008 PA 4 □ Donation 5 □ Other (Specify) Altoona 21. Signature Fundal/Seria Livens 22. Name and Address of Facility
Scarpeili Funeral Home, PA for Berkebile FH 108 Virginia Avenue: Cumberland, MD 21502 233 Fart | Enter the disease or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immedi e Cause (Final disease or condition resulting in death) **Physician** ALDIOMYOPATHY 6 MONTHS /Medical Due to (or as a consequence of): Examiner AmyLuidasis 9 MUNTHS Sequentially list conditions, it any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dun to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ∰Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours a To the Funeral I

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

Greag L

DHMH 17 Rev 1/2001

32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

042054

DONOLDSON 912 SETON DRIVE Cumberland, MD 21502

29d. Date signed (Month, Day, Year)

			1 _ State	ryland / Depa	artment of H	Health and M		_	jible.			
· F	Physicia	an	1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) THATCHER S. EDMUNDS					th Day	U U 8 2008	3. Time of Death 1315 P M		
)	/Medic Examin		4a. Facility Name (If not institution, give street and number) 31610 MILLER ROAD	4b. City, Town, or Location of Death CORDOVA			4c. Coun	4c. County of Death TALBOT				
	uneral rector			(In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day AUG 25,	rth 9. Birthplace (State or Foreign					
faryland	show ed at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			-		11	0d. Inside City Limits 1 ☐ Yes 2X No		
vith the N	or 28a-f be notifi	Director	MD TALBOT 10e. Street and Number	CORDOV	10f. Zip Code		1	10g. Citizen of	f What Coun	T		
:1215-UU36 within 72 hours after death with the Maryland ene.	marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at	by Funeral	31610 MILLER ROAD 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes ② N If Yes, Give Year or Dates:			625 Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bl Spec	USA ace - America ack, White, o			
J-CL2 thin 72 h		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	(Give	dent's Usual Occup kind of work done DO NOT use retire	ng	16b. Kind of Business/Industry					
		To Be Con	11 0 17. Father's Name (First, Middle, Last) VERNARD EDMUNDS	S	<u>UPERVISOI</u>	TRUCKING Maiden Surname)						
Mary of 2 shou th and N	7 is n		19a. Informant's Name/Relationship (Type. Print) EVELYN EDMUNDS/WIFE			t and Number or Rura			,	,		
Ore, jes 1 ar of Hea	If item 2 or other		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other pla	ice)	ate	20c. Location	- City or To	wn, State		
Saltimor permit. Pages Department of	Important: any injury o once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		2. Name and Addre	ess of Facility	/2008 & NEUN		VA, MI			
	= 8 0		FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between									
Physician /Medica Examine Asician and the burial-transit	edical miner purisher sician and purisher sici	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Onset and Definition of the PLATOCELLULAR (LARVINOMA) Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):									
the death certificate	been signed by the attending phys	Physician/Medic	in the past 12 months?	st 12 months? 4 Pregnant at time of death 5 Other (specify)						23d. Date of delivery Month Day Year		
uires that	signed b	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of							ne cause of death?		
The law requires that the	te has been age 2 shoul	Completed	24a. Was an autopsy performed? 1						24b. Were autopsy findings available prior to completion of cause of death?			
Of VICAL Physician: 7	certifica irector, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 № No Hospital: 1 ☐ Inpatier	A 0.5158/0	oth 3CIDOA Oth	26. Place of Death	(Check only or	ne)				
Attending Phy or death.	ral Director: After th	Certification: To	27. Manner of Death 1 ∰ Natural 5 □ Pending (Month, Day) 2 □ Accident investigation		of 28c. Injury at Work? M 1 Yes 2 No					2		
tal or Att		Sertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injurble building, etc.	reet, factory, office 28f. Location (St. City or Town			treet and Number or Rural Route Number, rn, State)					
To the Hospital or Attending within 24 hours after death.		Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To th	COLLIN	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							Day, Year)		
2		-	30. Name and address of person who completed cause of de	ath (Item 23a) (Type,	Print)	5043		5/1	010	Q		
3	- Cl	0		RATLROAD A		CENTREVILL	E, MARY	LAND 2	1617			
F	Stat Registra	e ir	31. Date filed (Month, Day, Year) 32. Registral	's Signature								

DHMH 17 Rev 1/2001

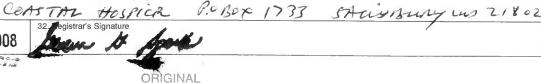
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death O8 Day Physician van 0 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico 9 If Under 1 Months 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) (In yrs. last birthday, **Funeral** 1 □ M 2 🗹 F Director 213-14-626 1/11/1926 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No dicomico Director 10e. Street and Number 10g. Citizen of What Country? Hickman Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tes 2 VNo If Yes, Give Year or Dates: 1 Never Married 2 Married re, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 □ Divorced Blac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Illinore,
It Pages 1 and 2 should be filed within 72 of the filed within 72 of the filed within 72 of the filed within "int Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 is marked other th any in Jury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Box 43 Nanticolle Annette Evans 21840 MD daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Cemetery Nanticoke, MD 6/14/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura de la ervio Licensee 917 W. Isabella St. Bennie Smith Funcial Home Saisbury, MD 21801 23a. Part1. Enter the disease shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPLE MYRLOMA /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ned by the attending physician detached for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2/☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📶 Ño Medical Certification: To 1 Tinpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State Registrar

6 Humm withy

AUN 1 1 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20780 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 4.45 PM Feller Herbert lune 33, 300g /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Lions Center for Rehabilitation Cumberland Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Hours 1□ M 2□ F Days Feb 19, 1918 Director 232-09-5763 90 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitied at once. WV Mineral 1 □Yes 2□No Director Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26726 USA West Piedmont Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Xio Baltimore, Maryland 21215-0036 Specify: Completed by Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Tri-State Paper Co. laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar Feller Maurcie Feller ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13105 Woodbridge Lane Cumberland MD 21502 Cheryl Porter niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/25/2008 Scarpelli Funeral Home, P.A. MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, of complications, or heart failure. List only one Immediatal Cause (Final disease or condition resulting in death)

a. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e.cause on each line. Approximate Interval Between Onset and Death Physician stage End 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Director (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown signed by the al d be detached fo 5 Other (specify) 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an page 2 s autopsy perform 1∐ Yes ospital or Attending Physician: 1 hours after death. Ineral Director: After this certifical y filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 XNatural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28h. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in time certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

worrow str

925 WONSOCK SHIN MD 32. Registrar's Signature JUN 2 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BISHOP

MD

29c. License number

00055325

29d. Date signed (Month, Day, Year)

WALSH RD Cumberland, MD 21502

June 24, 2008

State of Maryland / Department of Health and Mental Hygiene 2000

			1 - State Registrar		Ce	rtificate of l	Death	R	eg. No.	18 2018		
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death		
4	/Medic					June			2008 Y	11:40 A ^M		
	Examir	er	4a. Facility Name (If not institution, give street and number) 6644 24th Street			4b. City, Town, or Location of Death Hyattsville			4c. County of Death Prince George's			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,			_	If Under 24 Hrs. Hours Min.	Hrs. 8. Date of Birth 9. Birthplace (State or For				
	and		Usual Residence of Decedent 10a, State 10b, County	10c. City	y, Town or Lo	cation				10d. Inside City Limits		
	e Maryl 8a-f sho	ctor	MD Prince George Hyattsville							1 🖾 Yes 2 🗆 No		
	with the	Dire	10e. Street and Number 6644 42nd Street			10f. Zip Code 2078	2	1	0g. Citizen of Wha	at Country? aica		
	death ms 23	nera			S. 13.	B. Was Decedent of Hispanic Origin? (Specify Yes or Note of N			14. Race -	American Indian,		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ith Medical Examinar must be notified at once.	Completed by Funeral Director	1 ☐Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:					Black, White, etc. Specify: Jamaica			
15-0	"natu	letec	15. Decedent's Educat (Specify only highest grade c						16b. Kind of Business/Industry			
212	within iene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		Improveme			Private-	Real Estate		
	e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last)	1			18. Mother's Nam					
ylai	2 should be filed within and Mental Hygiene. is marked other than raumatic event, the Manatic event, the Man	2	James Uriah Frith		1		Hilda El:	izabeth l	Matthews			
Mar	12sh thand 7ism traum		19a. Informant's Name/Relationship (Type.		l	ng Address (Street a			-	•		
ē,	s 1 and 2 f Health item 27 i		Marcia Frith/ Daught 20a. Method of Disposition			3650 King sition (Name of natory or other plac			O ON MII	M329 Canada_ y or Town, State		
Baltimore, Maryland	permit. Pages 1 Department of H Important: If ite any injury or ot		1 ☐ Burial 2 🛣 Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)		Linco	ln Cremat	ory 06/1	1/2008	Brentwood	d, MD		
Bal	permit Depar Impor any in once.		21. Signature of Funeral Service Licensee	riller	ł	2. Name and Address 401 Blade	Fi		ln Funera			
			23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one	ions that caused the death cause on each line.						Approximate Interval Between Onset and Death		
-	Physician /Medical		disease or condition resulting in death)									
	Examiner			C HROW		EMML	FAIL	1100				
	7 +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):								
	ecuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		triery	DISE	HE					
68760,	fficate be executed g physician and is the burial-transit			Due to (or as a consequ	ience or):							
687	certificate ding physice as the	Medical	d									
Box	eath cer attendin for use	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnar	death 3	Ectopic pregnancy	,		23d. Date of			
0.	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5	Other (specify)			Month	Day Year		
т. О.	that the		Part II. Other significant conditions contrib	nderlying cause give	derlying cause given in Part I. 23e. I			olid tobacco use contribute to the cause of death?				
of Vital Records,	w requires to been signal should be	Completed by						1 X Ye	es 2 🗆 No 3[☐ Probably 4 ☐ Unknown		
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alB								perform	ned? dea			
ΖĬ	9 6 8i	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos	pital: 1 ☐ Inpatient 2 ☐ I	EB/Outpation	Othe	26. Place of Deat			(0 - 17)		
	g Physter this neral di	n: To	27. Manner of Death	28c. Injury Work	4 □ Nursing Ho		idence 6 ☐ Other (Specify) how injury occurred					
sior	Attending ir death. ector: After by the funer	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No								
Division	Pir Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, streeth building, etc. (Specify)			eet, factory, office 28f. Location City or T			(Street and Number or Rural Route Number, own, State)			
4	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a, Certifier (Check only one) 1 Certifying Physic 2 Medical Examiner	lan: To the best of my known: On the basis of examinat and manner stated.	wledge, deat tion and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occur	and due to the c red at the time, d	ause(s) and mann ate and place, and	er as stated. If due to the cause(s)		
-	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number			29d. Date signed (Month, Day, Year)					
			> Stulm T.	THE MU		146	998	-	June 11	, 2008		
	2		30. Name and address of person who comp	ND 3UIS	23a) (Type,	Print) DA6	ST HY	Albuil	U MD	20782		
	Sta	te	31. Date filed (MOX), [av.2/ea/008	32. Registrar's Simpat	ture	W	1					

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Physician Month Rena Forbes Margaret 6:10pm 2008 June 7, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner South River Health Care & Rehab. Anne Arundel Edgewater If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 1 ☐ M 2 🕱 F Nov. 1, 1940 Baltimore, Md. Director 218-52-6123 67 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Middeal Exercising must be notified at 1X Yes 2 □ No Director North Carolina Goldsboro Wayne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or with 101 South Virginia Street 27530 United States Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Farm Hand permit. Pages 1 and 2 should be filled win Department of Health and Mental Hygien Important: If Item 27 is marked other this any injury or other traumatic over 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0den John T. Forbes, Sr. Rena 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 101 South Virginia Street Goldsboro, N.C. 27530 John T. Forbes, Jr. /Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 14,200\$ Resurrection Clinton, Md. 22. Name and Address of Facility Alexander S. P 5538 Mariboro 21. Signature of Funeral Service Lig Pope. P.A. Pikė/Forėstville, Md. 20747 23a. Part Y. Eriter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) therosclerotic **Physician** Cardio vas wlardisease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 □Yes 2 ☑No Ö been signed by the should be detached 9 Unknown 9 Unknown <u>~</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 ardiomyo pathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a, Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 🔀 No of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica stelly filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2∏No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division XXX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide n 24 hou. the Funeral Dire 29a. Certifier 1፱ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal within 24 ho

To the Fune

completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50653 -10-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN. C 5851 eale 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrameno#5, perFH, 6/20/08, DPS, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician 8:51A M 2008 FRANKEL JUN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Hebrew Home of Greater Washington Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Socrity 29729 **Funeral** Days Hours Months 1□M 2□F 96 10, 1912 Massachusetts Director Jan. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 'natural", or Items 23a 6105 Montrose Road 20852 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or Items 23s any injury or other traumatic event, the Medical Examiner must gonee. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname)
Jennie S. Weiner 17. Father's Name (First, Middle, Last) ag Joseph Titelman ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackie Gladstone, Niece 11406 Tanbark Drive, Reston, VA 20191 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation % Removal from State 4 Donation 5 Other (Specify) King Solomon Memorial Park 06/15/D8 Boston, MA 21. Signature of Eur Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniorlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Vear 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy nerformed' 2/ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D57284 2008

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State Registrar 31. Date filed (Month, Day, Year) 33. Re JUN 12 2008

ANNA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



6105 MONTROSE ROAD

			State of Maryland / Department of Health and Mental Hygiene 1- For State State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2078									4	
	Dhysisi	an.							2. Date of Death Month Day Yeer 3. Time of Death				
	Physici /Medio		LORENZO	FORD				JUNE	08,	2008		12 a	VI
	Examir	er	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death			County of De			
			MONTGOMERY COUNTY 5. Social Security Number 6. Se		IOSPITAL ge (In yrs. last birthday)	ONLEY	If Under 24 Hrs.	8. Date of Bird		NTGOM		ate or Foreign	20
	Funeral Director			XM 2□F	7.3 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	35 Was	irthplace (St Country) shingt		
	ס		Usual Residence of Decedent					Joans 1.	,, 17	33 Was	J.1.1.1.6 C	011,01	
	arylar show	_	10a. State 10b. County	0	10c. City, Town or Lo							de City Limit Yes 2 ☐ N	
	he M	Director	Maryland Prince	Georges	Upper M				10 000			163 2	
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	ns 23	Funeral	10810 Knoll Ct.	12. Was Decedent		20772 Was Decedent of Hi	spanic Origin? (Sp	pecify Yes or No		4. Race - An		in,	
9	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s or 28s-1 show to Madreal Evarinet must be rediffed at	Fur	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 Yes 2 If Yes, Give	No No	If Yes, specify Cubai	n, Mexican, Puerto	Rican, etc.)		Black, Wr			
21215-0036	ours Fra	d by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2 🙀 No	<i>Specify</i> :			Specify: B	к 		_
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5	Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)	5 +		logist	18. Mother's Nam	e (First, Middle,			GOVEL	IIIIEIIC	
Maryland	uld be Aenta rked tic ev	To B	Hardy Ford				Hattie	Isler					
ary	and N		19a. Informant's Name/Relationship (7)	γρθ, Print)		ng Address (Street a							
Σ,	and and m 27		Pamela S. Ford	/ Wife		0 Kno11 C	1000 1000)772		
Baltimore,	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23s or 28s-1 show or other freumetic event, If a Phatles Examine must be notified at		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	Removal from State	20b. Place of Dispo cemetery, crea	sition (Name of matory or other place	9)	Date	20c. Loc	ation - City o	or Town, Sta	te	
Ë	t. Pa ntmen rtent: njury	i ii	'4 □Donation 5 □ Other (Specify)		Maryland			9/2008		tenhar	-		
Ba	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu		21. Signature of Funeral Service Licens 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 marlboro Pike Forestville, md. 20747										Ì
			23a. Part . Zhrer the disease, or compleshock, or heart failure. List only o	lications that caused ne cause on each li	d the death. Do not en ne.	er the mode of dying	g, such as cardiac	or respiratory ar	rrest,			imate I Between and Death	
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	/Medical Examiner				a consequence of):								
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o,	an an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):										
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9	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	0	IF FEMALE:										_
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Division of	ding P h. After I funera	Certification;	27. Manner of Death 28a. Date of Injury 1 X Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work? 1 1 Yes 2 No								ury occurred		
<u>S</u>	I or Attendi after death. Director: A I in by the fu	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Ini	ury - At home, farm, str		95 2 100	28f. Location (5	Street and	Number or i	Rural Route	Number	-
2	after of Direct of in by	ertii	4 Homicide determined	oot, lactory, diffee	actory, office 28f. Location (Street and Number or Rural Route City or Town, State)								
	To the Hospitel or Attending Physicien: within 24 hours after deals at the full of the Funerel Director. After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 🕱 Certifying Phy 2 Medical Exami	sician: To the best ner: On the basis o and manner st	of my knowledge, deat f examination and/or in	n occurred at the time vestigation, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) a	and manner and di	as stated. ue to the cau	se(s)	
	To the within 2 To the Complet	Mec	29b. Signature and title of certifier	LO .	acou.	29c. License	number		29d. Date	signed (Mo	nth, Day, Ye	ar)	
	- S F O		Saima	Khow	voys	D00589	65		JUNE	10,	2008		
	(7)		30. Name and address of person who co	empleted cause of d	leath (Nem 23a) (Type,		ر ن		ONE	10,	2000		
_				, M.D. 11	119 ROCKVI	LLE PIKE	, SUITE	100- RO	CKVII	LE, M	D. 208	52	
	Sta	_	31. Date filed (Month, Day, Year) JUN 1 3 2008	32. Registr	ar's Signatud.)							
	Registr	ar	TOM T & SOOR	Diduct A	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20785 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** 10:00 p^M June 07 2008 Marvin Charles Fuchs /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 XM 2 ☐ F 01 1929 78 Nov Director <u> 216-28-0239</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. inside City Limits 10a. State fshow r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at MD Carroll Westminster 1 ☐Yes 2 TXNo by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21158 USA 718 Collier Ct 12. Was Decedent Ever in U.S. Armed Forces? 1 X2 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married WII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Mechanical Engineer Ith and Mental Hygie 27 Is marked other t r traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Treuchel Charles Paul Fuchs 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau MD 21158 20c. Location - City or Town, State 718 Collier Ct Westminster, Anna Fuchs/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 06/13/2008 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation, Inc Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 2Practets Afunerally Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 21157 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. proximate rval Between Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ 2 No 3 Probably 4 → Onknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be KOUSC Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ² 1 🔲 Inpatient 27. Manne of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury Certification: (Month, Day Year) 1 **⊡**Natural 5 ☐ Pending investigation s after de... al Director: An 1 TYes 2 TNo 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatu and title of certifier WIL

State Registrar

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31. Date filed (Month, Day,

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to Street Wastminster, MD 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Physician Geary 20 2008 Harden JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Allegany** Cumberland Memorial Hospital Birthplace (State or Foreign Country) Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Sep 21, 7. Age (In yrs. last birthday) ocial Security Number **Funeral** 1 M 2 F Director 218-12-5377 84 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Yes 2□No ral", or items 23a or 28a-f shov Examiner must be notified at Cumberland Allegany MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21502 48 Oak Street permit. Pages 1 and 2 should be filed within 72 hours after death \(\text{Department of Health and Mental Hygiene.} \)
Important: If item 27 is marked other than "natural", or items 23a amy injury or other traumatic event, the Medical Examiner must once. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐No Specify: Specify: white Baltimore, Maryland 21215-0036 ğ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MD Dept. of Transp. secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia E. Feidt Harden Harold B. Harden ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) MD 21502 Cumberland 501 Beall Street daughter Ruth Summers 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3 Removal from State 1 ■ Burial 2 □ Cremation 6/24/2008 MD Sunset Memorial Park Cumberland 4 □ Donation 5 □ Other (Specty) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Sp 23a Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate of use (Final disease or to dition resulting in eath)

a. Pus to (Screening and Mark) 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) Examine The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No detached for 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) To Be Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 70 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi

State Registrar

31. Date filed (Month, Day, Year)

JUN 2 6 2008

DHMH 17 Rev 1/2001

Robert A. Welik, MD, 902 Seton Dr. Suite 308, Cumberland, Md

JUNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>008</u> Month **Physician** Рм Pauline Barbara Gasparovic 3:25 June 17, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 19699 N. Snow Hill Manor Road St. Mary's City St. Mary's If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🕅 F 577-16-7809 90 Director February 14, 1918 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Director Maryland St. Mary's St. Mary's City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19699 N. Snow Hill Manor Road 20686 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: <u></u> 3 ☐ Widowed 4 🖾 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Court Reporter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin Gasparovic Anna Hradsky ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i 20686 Anna Vecera / Cousin 19699 N. Snow Hill Manor Rd. St. Mary's City, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State June 19 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 20Ó8 21 Signature of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P. P.O. Box 270 Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** aontic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner horosclerotic cardiovascular disease esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) ed by the a detached f signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed' 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Magner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation To the Hospitar c. within 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

29b. Signature and tifle of certifier

31. Date filed (Month, Day, Year)

attending

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas M. Willanson, M. V. 23130 Mogkley Styleonardtown,

Blow & Sparle

29c. License number

D0055682

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Violet Louise Green June 10. 2008 1:50 P.M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village Health Care Center Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 21€ F Director 094-44-0690 82 9, 1925 Oct. Jamaica Usual Residence of Decedent 72 hours after death with the Maryland show 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the involcal Evantings must be notified at Director 1 ☐ Yes 2X No Maryland Montgomery Montgomery Village 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 19301 Watkins Mill Road 20886 Funeral United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2X No Specify: 2 3 Widowed 4 Divorced Specify Year or Dates **Black** Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Nursing permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other than injury or other traumatic annother 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Unknown Adicia Morgan Alabourer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly C. Spitler/Minister 22101 Goshen School Rd., Gaithersburg, MD. 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gardens 6/16/08 Frederick, Maryland 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 21. Signature of Funeral Service Licensee Maons 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each ling. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseq To Examiner Sequentially list conditions Examine if any, leading to immedie cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last executed and Due to (or as a consequence of) burial-Box 68760. physician certificate be Physician/Medical the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery that the death Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 ☐ Other (specify) Ö been signed by the should be detached 9 Unknown 9 Unknow 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 ☐ Yes 2 No 2 No Division of Vital Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death
1 Natural
2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury death. 24 hours after death.

E Funeral Director: A letely filled in by the form 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and the of certific 29c. License number 29d. Date signed (Month, Day, Year) 005757 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Dr., Suite 201, Rockville, Maryland 20850 Ahmed Heshmat, M.D., 31. Date filed (Month, Day, Year) State 2008 **JUN 13** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 09 Paul Matthew Grist June 2008 1:36 aM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 49 Yrs Virginia Director 213-80-3541 September 18,1958 Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examinar must be notified at Director 1 ☐ Yes 2 X No **Maryland** Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1201 Twig Terrace 20905 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ♣ No ģ Yes Give Specify: Specify: 3 Widowed 4 Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teledata Technician Power Services, Inc. is marked other tof Health and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Edgar Ernest Grist, Jr. Norma Jean Hummer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa A. Grist - Spouse 1201 Twig Terrace, Silver Spring, Maryland 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 06/12/2008 Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licens Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that causeu be beart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Final disease or condition resulting in death) **Physician** Kespala /Medical Due to (or as a conse un nce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last neumania Examiner Due to or as a consequence of requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 Other (specify) P.O. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho autopsy page performed? this certificate of Vital 1 □ Yes 2 NO or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After thi funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director; Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 — ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 — Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29a. Certifier (Check only

29b. Signature and title of certifie

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

2 2008

MI

Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

29c. License number

18101 Pome Philip Dr MD 20800

29d. Date signed (Month, Day, Year)

red Direct

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<u>008</u> 9:12 A M John Richard Herbert June 19, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Harford Bel Air 8. Date of Birth (Month, Day, Year) Feb. 18, 1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 12 M 2□ F Months Days Hours 67 1941 213-38-8521 PΑ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 🏖 No Jarrettsville Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2042 Nelson Mill Road 21084 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15, Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Trucking 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Corrine Heaton Samuel Alton Herbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2050 Nelson Mill Rd. Jarrettsville, MD 21084 Patricia Herbert/Sister 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 24. 20a. Method of Disposition st. Paul United Methodist Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State Pylesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.J. Hartenstein Mortuary, I Rel 19 S. Main St., Stewartstown, PA 17363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Adenocarcinoma disease or condition resulting in death) month Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

an "natural", or items 23a or Medical Examiner must be

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and Mental Hygie m 27 is marked other th.

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau

Pages 1 and 2 should

or items

Director

Funeral

Completed by

Be

MD

attending physician for use as the buria signed by page 2 : certificate

Physician/Medical

Completed by

Be

P

Certification:

Medical

1erbert John Richard McCold Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

1 ☐ Yes 2 ☐ No

9 Unknown

in the past 12 months?

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9☐ Unknown

Due to (or as a consequence of):

3 Ectopic pregnancy 5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

23d. Date of delivery

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin-dependent diabetes Obstructive sleep aprico

24a. Was an perform

1 Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Day

Year

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier

a Rea

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pper Chesapoake Dr. Beldir, MD 21014 acc 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

5

To the Funeral Director: A

To the Funeral Director: A

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87	Physicia		1. Decedent's Nam	ne (First, Middle								2. Date of De Month	Da	y Year	3. Time	of Death
	/Medic					tie Hil	1								9:30	<i>P</i> • M
	Examin	er			n, give street and nu			4b. City,					40	c. County of Dea		
	Funeral		Golde 5. Social Security I		ng Center 6. Sex	Sex 7. Age (In yrs. last birthday)			1 Year	ersto If Under	24 Hrs.	8. Date of Bi	rth	Washi 9. Bi	<i>ngton</i> thplace (<i>State</i>	or Foreign
	Director		215-09-93	360	1 □ M 2 X F	99	Yrs.	Months	Days	Hours	Min.	(Month, D. May 13				
	pu ,	Ì	Usual Residence of 10a. State	Decedent 10b. County		10c Ci	ty, Town or Lo	cation				10			10d. Inside	City Limits
	/anyla	ō	Md.		hington	100. 01		iams po	n+							s 2 No
	be filed within 72 hours after death with the Maryland tial Hyglene. ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Nu		11119 2011		W T T T T	10f. Zip		-			10g. C	itizen of What C	ountry?	
	h with	al Di	106 Art	izan S	t.				2.	1795				U.S.A		
	ems 2	ner	11. Marital Status		Armed F	cedent Ever in U	J.S. 13.	Was Deced	lent of His	spanic Or	rigin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh		
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Ö	hours tural		21∠X widowed	15. Deceden		Jates:	16a, Dece	dent's Usua	al Occupa	ntion			16b.	Kind of Business	/Industry	_
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pu	be filed tal Hygid d other event, tl	Be (17. Father's Name	(First, Middle,	Last)					18. Moth	er's Name	(First, Middle	e, Maide	n Surname)		
Maryland 21215-0036	2 should be and Mental is marked or raumatic eve	ဥ		ert Lee			T 400 44 10		(2)			Keller		O	7. 0	
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IOL	Pages ent of nt; If II		1 Dunal 2		3 ☐Removal from	State]	cemetery, crej Rivervi	matory or o	mete inete	ry	July	₂ 10,200	98 W	illiams theburg	port ,N	1 D.
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m	De III		Jell	en les	DAVI	MO14.	J.					Home S	mith	sburg,M	đ. 2178	33
	Physician /Medical Examiner		Immediate Cause disease or conditi resulting in death)	(Final on	complications that only one cause on Due to	quence of):			g, such as		or respiratory	arrest,		Approxim Interval B Onset an	ate etween d Death	
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20,0	e executed an and irial-transit	Еха	resulting in death)	Last	Due to	(or as a consec	quence of):									
9289	ate be hysici the bu	lical			d											
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0	iw requires that s been signed by should be deta	d by Ph	Part II. Other sign	ificant condition	ons contributing to o	death but not res	sulting in the u	nderlying ca	ause give	en in Part	ţ			use contribute	t t	f death? Unknown
Division or Vital Records,		Completed by											s an opsy formed? 2VIN	prior to death?		s available cause of
/ita	clan: ertifica	Be	25. Was case refe examiner?	erred to medica								(Check only				
Jr V	<u>≥</u> .≅ Þ	၉	1 □ Yes 2 □	, No			ER/Outpatie			4/C N				6 □Other (Sp	ecify)	
on c	ng fte	ion:	27. Manner of Dea	5 Pendin	194	nth, Day Year)	28b. Time o	M 2	8c. Injury Work	rat ?? ∕es 2 ⊑		28d. Describe	how inj	ury occurred		
isio	Attending r death. ector: After by the fune	icat	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	not be	e of injury - At h	nome, farm, sti			165 2 [28f. Location	(Street a	and Number or I	Rural Route Ni	umber.
Ω̈́	after after Dire	Certification:	4 Homicide	determ	build build	ding, etc. (Speci	ify)	, ,				City or To	own, Sta	te)		,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)	Certifyir	ng Physiclan: To the Examiner: On the and mai	e best of my kn basis of examin nner stated.	owledge, deat ation and/or in	h occurred evestigation	at the tin	ne, date a pinion, de	and place, eath occur	and due to th	e cause e, date a	(s) and manner nd place, and d	as stated. ue to the caus	e(s)
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	ф.		30. Name and add	iress of person	who complèted cau	MM	m 23a) (Type, 368	mu	Ül	Str	all	· Houg	feste	-20-00 un 19	0217	40
	Sta Registr		title a a committee of the second of the sec													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2008 20792 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JUNE 9, **Physician** 2008 2:30 AM M BERTHA HAMILTON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HEARTLAND HEALTH CARE NURSING HOME PRINCE GEORGE HYATTSVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 3-7-1919 Birthplace (State or Foreign Country)
 NC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Days Hours 1 ☐ M 2 ☐ F 578-24-7795 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Medical Examinar must be notified at 1 Ty Yes 2 □ No Director MD PRINCE GEORGE LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tems 23a or 7904 POLK STREET 20706-1741 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 le marked other then "naturel", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK þ 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Complete 12TH GRADE College (1-4or 5+) SALES CLERK WOODWARD & LOTHROP 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BOSTON TETTERTON EVA LITTLE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at Important: If Item 27 le
ony injury or other trau WALTER SWINDELL-COUSIN 7904 POLK STREET LANHAM, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State LINCOLN MEMO. CEM. 6-16-08 SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 21. Signature of Funeral Service Licenses 524 - 5TH ST., N. E. WASH., DC 20002-5236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DIOPULMONEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine -transit The law requires that the death certificate be executed and physicien ar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 99 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 No this certificate 1 Yes 2 No 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 Yes 2 No ġ 2 ER/Outpatient 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 146529 30. Name and address of person who completed cause of death (Item 23a (Type, Print) 7325A HOMOVER PARKWAY GREENBELT MARTHAND 20710 31. Date filed (Month, Day, Year) 32. Registrar's Sign State JUN 1 2 2008 Registrar

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinations is not the required at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

			10e per fh, gc	C6	ertificate of D	Death		Reg. No. 2	800	20793		
nysici	an	1. Decedent's Name (First, Midd			TI A T T		2. Date of De	Day	Year	3. Time of Death		
Medic		CAROLYN 4a. Facility Name (If not institution	C.		HALL 4b. City, Town, or	Location of Deat	JYMe		y of Death	444PM		
xamin	er		UNITY HOSPITAL		LANHAM	LOCATION OF BOOK	•		E GEO	RGE		
neral		5. Social Security Number 577–54–0831	6. Sex 7. Age (//	n yrs. last birthdaj Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D) 9-7-3	1	9. Birthp	lace (State or Foreign try) CITY, SC		
ector		Usual Residence of Decedent	77				9-7-3		LAKE	CIII, SC		
Med at	ctor	DC 10b. County		oc. City, Town or L					10	0d. Inside City Limits 1 XYes 2 ☐ No		
or ed lau	Funeral Director	10e. Street and Number 426 ALLISON ST	REET, N.W.E.		10f. Zip Code	0011		10g. Citizen of U.S.		try?		
important, it rent 27 is marked unter trial. Itatural, or reins 25a or 20a-3 show any injury or other traumatic event, the Modical Examiner is ust be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Mai 3 □ Widowed 4 □ Divorced	If Yes Give	r in U.S. 13	8. Was Decedent of His If Yes, specify Cubar 1 Yes 27 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		ice - America ick, White, e ify: BLA	etc.		
the Medical	Completed	15. Decede (Specify only highe Elementary/Secondary (0-12) 12TH GRADE	nt's Education est grade completed) College (1-4or 5+)	(Giv life.	sedent's Usual Occupa ye kind of work done di DO NOT use retired) FT WRAPPER	uring most of wor	king	16b. Kind of E		STORE JEWELRY		
tic event,	To Be C	17. Father's Name (First, Middle WILLIE EDWARD	•			18. Mother's Nan ROSA MA	ne (First, Middle AE GASKI		me)			
er trauma		19a. Informant's Name/Relation: REV . BETTY LOGA			iling Address <i>(Street a</i> LEDEL CT.				n, State, Zip	Code)		
ury or oth		20a. Method of Disposition XX Burial 2 □ Cremation 4 □ Donation 5 □ Other (3	3 Li Hemovai from State	FT. LIN		RY 6-17		20c. Location BRENTWO	OD, MI)		
any in		4 Donation 5 Other (Specify) FT. LINCON CEMETERY 6-17-08 BRENTWOOD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 524 - 8TH ST., N. E. WASH., DC 20002-5236										
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O) Stat		30. Name and address of person 31. Date filed (Month, Day, Year)	eorge 7500 32. Registrar's	(Item 23a) (Type O Hanos Signature	ver Parkan	ay, Ste	101A, C	Sreenb	elt	2009		
gistra	ar	JUN 1 2 200	10 Bleeve St	Appeal								

			State of Mar				d Mental Hyg	jiene		
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of	Deam	2. Date of Dea	leg. No.2 0	08	20794
	∍Physici	an	James Wesley Ham				June 16		Year	10:25 P _M
ig.	/Medio Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	b. City, Town, or Location of Death			4c. County of Death	
7	LAdiiii		22031 Cartwright Road					S	t. Ma	ry's
	Funeral Director		373-28-8233 1X M 2□ F	78 Yrs. Yrs.	If Under 1 Yea Months Days		lin. 8. Date of Birth (Month, Day January 1	, Year) 3, 1930	Coui	place (State or Foreign ntry) igan
	w .		Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or Lo	cation				1	10d. Inside City Limits
	se Maryla Ba-f sho stified at	Director	Maryland St. Mary's			ardtown				1X Yes 2 □ No
	th with the		10e. Street and Number 22031 Cartwright Road		10f. Zip Code 20650			10g. Citizen of	What Coul USA	ntry?
215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural," or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Event Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	er in U.S. 13. \	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No		? (Specify Yes or No- uerto Rican, etc.)	Bla	ce - Americ ck, White, y: Whi	
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Mai	d 2 shouth and the and traums		19a. Informant's Name/Relationship (Type. Print) Dorothy M. Ham / Wife		Box 575		r Rural Route Numbe ${ m dtown}$, ${ m MD}$, State, Ziţ	o Code)
	s 1 and 2 f Health item 27 l		20a. Method of Disposition	20b. Place of Dispo		laca)	Date	20c. Location	- City or To	own, State
altimore,	Pages nent of I		1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (<i>Specify</i>)	Charles Mer		dens Ju	ne 20, 2008	Leonardto	own, M	aryland
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Records,	The law require cate has been single page 2 should be	Completed							Were autoprior to codeath?	opsy findings available ompletion of cause of
Vital		Be C	25. Was case referred to medical examiner?			26. Place of	Death (Check only or			
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ou c	ing Affe une	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day) 2 ☐ Accident investigation	(ear) 28b. Time o	W	jury at ork? □ Yes 2 □ No	28d. Describe h	ow injury occu	rred	
Division	or Attender ter death	Certification:	- C Could get be	- At home, farm, str (Specify)			28f. Location (S City or Tow	Street and Num vn, State)	ber or Rur	ral Route Number,
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	To th within To th comp	Me	29b. Signature and title of certifier	~	29c. Lice	nse number	59	29d. Date sign	ed (Month,	, Day, Year)
			30. Name and address of person who completed cause of dea Umed K. Shah, M.D. 26840 Point Loc			od, MD 206	536			
	Sta Regista		31. Date filed (Month, Day, Year) JUN 1 7 2008	_		-				
				,						

DHMH 17 Rev 1/2001

ORIGINAL

Certificate of Death

2. Date of Death

14, 2008°

4c. County of Death

St. Mary's

14. Race - American Indian,

Black, White, etc.

Specify: White

1:20 A.M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Years

Years

24b. Were autopsy findings available prior to completion of cause of

death? 1 ☐ Yes 2 ☐ No

23d. Date of delivery

Month

1 ☐ Yes 2X No

June

Decedent's Name (First, Middle, Last)

Thaddeus Stevens Hess Jr

Physician

/Medical

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D56096 June 14, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajbinder Gill,MD 26840 Point Lookout Road, Leonardtown, Maryland 32. Registrar's Signature

State

31. Date filed (Month, Day, Year) Been It food JUN 17 2008 Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Reg	. No. 2	nna	2079
2. Date of Death	_	000	3. Time of Death
Month	Dav	Year	

Physician /Medical Examiner

LOUIS HOOKER

JUNE

Year

М

2008 6:55PM

Funeral

Director

the Maryland show r 28a-f sh Director Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. o a Funeral ò Completed by "natural" the Medical Be 2

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

attending p this Director:

Division or Vital Records, P.O. Box 68760,

or Attending Physician: The law requires that the death certificate be executed Funeral D Hospital To the 5+VA

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TALBOT 9577 ENTRANCE LANE EASTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JUN 22,1930 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 ☐ F 77 MARYLAND 218-26-9958 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9577 ENTRANCE LANE 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HORSE_EXERCISER 0 HORSE RACING 77 Is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOSEPH HOOKER MARGARET M. KEHOE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l IRVIN HAYES/NEPHEW 9577 ENTRANCE LANE, EASTON, MARYLAND 21601 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. WOODLAWN MEMORIAL PARK 6/11/2008 EASTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Work resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown 23e. Did topecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 | Yes 2 | 1√10 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. SANCHEZ, M.D. 508 IDLEWILD AVE., EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year) , JUN 1 1 2008

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 819 M 2008 ara Une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 99 511 No Ver Drin 000 00mers 24 Hrs. 9. Birthplace (State or Foreign Country) Missouri 5. Social Security Number If Under 1 Year | If Unde Date of Birth (Month, Day, June 4 **Funeral** Months Days Hours Min 1 M 2 F 499-18-4467 86 Yrs. Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show 1 ☐ Yes 2 TNo Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10702 Tenbrook Drive 20901 USA Funeral tems 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner for 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 Yes 2 No ģ Specify Specify: **XX**Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Program Analyst Federal Government or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be permit. Pages 1 and 2 should be Department of Health and Mental Important; If item 27 is marked c any Injury or other traumosts. Claude Price Ruth VanOrsdale ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4608 Burlington Road, Hyattsville, James Henry/Son MD 20781 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State June Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 200 Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) erforated /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4/mongry Examiner Due to (or as a consequence of) the death certificate be executed hxocar 4ia and Due to (or as a consequence of) physician Box 68760 Physician/Medical the signed by the attending p IF FEMALE: yes, outcome of pre xan ☐ Live birth 2 ☐ Fetand 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth Month Day Year Pregnant at time of de Ö 1 ☐ Yes 2 ☐ No 9 Unknown (0 9 Unknown ۵. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? Records, ģ 3 ☐ Probably 2 No 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2. No certificate 2 No 1 ☐ Yes 1 ☐ Yes of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner/ 12≛Yes 2 🔲 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28d. Describe how injury occurred parapropration of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After Division 1 Natural 5 Pending investigation June 7 2705 / 2000 AM 1 ours after death.

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filled in by the fu death. 1 □ Yes 2 Accident dolon durin colonoscap 28f. Location (Street an Number or Rural Route an boy City or Town, State) | 500 | 7011 | 5 | 6 | 6 | 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide Nos Rd, Silver Sprim mo 20910 within 24 hours a 🔁 Certifying Physician: To the best of my knowledge 😅 th occurred at the time, date and place, and due to the cause(and ner as stated. Medical completely 2 Medical Examiner: On the basis of examination and manner stated. r investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mes and address of person who completed cause of death (Item 23a) (Type, Print) Medical Park Dr.

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31. Date filed (Month, Day, Year)

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 **Physician** Hatzenbuhler June 08, 2:30 P M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 415 Russell Avenue, #513 Gaithersburg Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours 1 □ M 2 🛣 F Davs 260-24-6154 83 **Director** Feb. 02, 1925 GA. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Martical Experiment. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2x No MD Montgomerv Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Russell Avenue, #513 20877 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married <u>8</u> 1 ☐ Yes 2 XNo Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Paul Whatley ပ Annie Gibson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Russell Avenue, #513 Gaithersburg, MD. 20877 Thomas M. Hatzenbuhler (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June Tate. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, VA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate fause (Final disease condition resulting in death) **Physician** gebrovascular years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the death certificate be executed burial-transi and Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 10 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has } autopsy performed? Yes 22 No this certificate 2 X No 1 ☐ Yes 1 Tes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 \sum Nursing Home မ 1□ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 ☐ Pending investigation To the Hospital or Attendinwithin 24 hours after death. To the Funeral Director: After completely filled in by the fur 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

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31. Date filed (Month, Day, Year)

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Ronald Holmes	

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edical Examin	er	RONALD	HOLMES		b Oits Tassa	Leastion of Dog	June 9, 200	4c. County of D	2312 hrs
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Funeral		5. Social Security Number 6. Sex	7. Age (in yrs. la	st birthday)	If Under 1 Yea				Birthplace (State or Foreign Country)
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2121! uld be fil. Mental F marked c event, i	B	JOHN HOLMES 19a. Informant's Name/Relationship (Type)	oo Print)	19h Mailing	Address (Stre	HATTIE		PRICE ber, City or Town,	State, Zip Code)
O 등 전 등 개	٩	DAISY M. HOLMES/		1				MARYLAND	T T
re, h	1	20a. Method of Disposition	20b. 1	Place of Dispos crematory or otl	ition (Name of c her place)	emetery,	Date	20c. Location - Ci	ty or Town, State
Limore, MD Pages I and 2 sh tment of Health an trant: If item 27 is		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:					18/2008		IAM, MARYLAND
Baltimore, ME permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum:	-[21. Signature of Funeral Service Licens	^V					KINS FUNE VER,MARYI	
Physician	\dashv		cations that caused the death						Approximate Interval Between Onset and
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ion of Vital Records, P.O. Box 68760, rending Physician: The law requires that the death certificate be executed cath. or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transitions.	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	2 F	etal death	3 Ectopic pre	gnancy	Month	Day Year
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B, P.C iires that signed to be deta	d by						1 Ye		Probably 4 Unknown ere autopsy findings available
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Sion Attendin death. ctor: A	atio	1 Natural 5 Pending 2 ✓ Accident Investigation	Jun 9, 2008	FOUND: 2230 hrs	1	Yes 2 No	temperatur	es	or Rural Route Number, City
Division of Vital Records, tall or Attending Physician: The law requirers after death. all Director: After this certificate has been steen by the funeral director, page 2 should the country that the country the country that	Certification:	3 Suicide 6 Could not l			зет, тастогу, опіс	e building, etc.	or Town,		
Div Hospita or 24 hours afte Funeral Dit		29a. Certifier 1 Certifying Physici	an: To the hest of my knowler	doe death occi	urred at the time	, date and place,	and due to the cau	se(s) and manner a	as stated.
Division To the Hospital or Attent within 24 hours after death To the Funeral Dir. ctor: completely filler in 19 the	Medical	one) 2 Medical Examiner	On the basis of examination and manner stated.	and/or investiga	ation, in my opin	ion, death occurr	red at the time, date	and place, and du	e to the cause(s) d (Month, Day, Year)
	Σ	29b. Signature and title of certifier	N 00 0 0	dia		ense number C.M.E.		June 10, 20	
12	ľ	30. Name and address of person who	completed cause of death (Itel	m 23a)					
RO			nt Medical Examiner	111 Penn	Street, Balti	imore, MD 2	1201		0
S Regis	tate		32. Registrar's Signa	Contraction of the second					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7008 Day Month **Physician** Brown Harris /Medical Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner A PLATA HARLE MEDICAL IVISTA Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕅 F Months Days Hours 237-26-5746 85 Director 1922 June 26, Tennessee Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at 1 □Yes 2 No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1026 Floyd Avenue 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 ☐ Yes 2 💢 If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: White <u></u> 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wn Department of Health and Mental Hygien Important: If them 27 is marked other them any injury or other treasment. Sales Assistant Manager Hecht Co Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Norman Brown <u>Velma Holt Brown</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tony Harris/ son 7335 St. Mary's Ave. La Plata, Maryland, 20646 Itimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gdns: June 16, 2008 Waldorf, Maryland 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, Maryland, 20501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Preumonia Aspiration Immediate Cause (Final **Physician** HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Years CEREBIOVASCULAR Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dinbetes 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?* Yes 2 D No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 24 hours after deatl 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

6

32. Registrar's Signature JUN 1 2 2008

OFFICE

Randleval

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POST

29c. License number

D0061614

R. SINDHWANI

WALDORF

29d. Date signed (Month, Day, Year)

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,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Registrar AMNED, ITEM#3perPHYS&FHCC World icate 8 beath 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 June 10 Mary Jeanette Henderson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis of La Plata La Plata Charles Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 84 1 □ M 2 X F 219-12-4022 1924 Maryland Director 29, Jan. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r 28a-f show notified at show 1 ☐ Yes XX No Directo Maryland | Charles Waldorf 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 2 r must be n 12782 Jones Lane Funeral 20602 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. "natural", or items 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 🛣 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) than <u>Dental Assistant</u> Dentistry Department of Health and Mental Hygin Important: If Item 27 Is marked other any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Francis Guy Welch <u> Marian Stinnett Welch</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Henderson/ Husband 12782 Jones Lane, Waldorf, Maryland, 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan June 12, 2008 Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 Part1. En/er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (o as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ss of p cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 1 2

2008

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Pagistrar's Signature

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April .	Exami		4a. Facility Name (If not institution, give			4b. City, Town,	or Location o			c. County of Dea	ath	
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	Funeral		5. Social Security Number 6. S	ex, 7. Age (In yrs	. last birthday)	If Under 1*Year Months Days	If Under 2 Hours		Birth Da <i>y, Ye</i> ar	9. Bi	rthplace (State of ountry)	or Foreign
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at once.		20a. Method of Disposition	20b.	Place of Dispos	sition (Name of latory or other pla	ce)	Date	1100	ocation - City or		
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_	ng life	ion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Worl	nyat k? Yes 2 ∐ N∈	28d. Describe	how inju	ry occurred		
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	To the hospital of Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	edical C	29a. Certifler (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at the tile estigation, in my o	me, date and opinion, death	I place, and due to the occurred at the time	e cause(s	and manner a d place, and due	s stated. e to the cause(s)	
	orthe orthe	Mec	29b. Signature and title of certifler	and manner stated.		29c. Licens	e number		29d. Da	te signed (Mont	h, Dav. Year)	
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		}	30. Name and address of person who d	ompleted cause of death (Item	1 23a) (Tyne. P				טטט	e 4,20	308	
			Melecia Santos	M.D. VA MATU	land 1	tealth C	ere S	stem, Per	Tru T	Point 1	MD 219	102
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	1	State of Maryland / Dep		Mental Hyg	•	<u> Դ և</u>
Physician	ı	1. Decedent's Name (First, Middle, Last) Myrna A. Hastings		2. Date of Deat Month June 7	h 3. Time of Death	a
/Medical Examiner	-	4a. Facility Name (If not institution, give street and number) 218 Pineway	4b. City, Town, or Location of Death	J	4c. County of Death Wicomico	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday, 70 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 11/14/		ign
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a or 28a-f si be notified	DILEC	10e. Street and Number 218 Pineway	10f. Zip Code 21804	10	Og. Citizen of What Country? USA	
be filed within 72 hours after death with the Maryland table flied within 72 hours after death with the Maryland table flied with the Medical Examiner must be notified at the Completed by Funeral Director		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white	
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and 2 shoralth and N		19a. Informant's Name/Relationship (Type. Print) Debbie Church/daughter 19b. Mail	ng Address <i>(Street and Number or Ru</i> .7 Linmont Lane, E	ustis, F	City or Town, State, Zip Code) L 32726	
Pages 1 and to the int. If item		1 Burial 2 Ni Cremation 3 Hemoval from State	matory or other place)	Date :	20c. Location - City or Town, State Salisbury, MD	
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15 CM		29b. Signature and title of certifier	29c. License number D 47 U 9 9 Print) STU- STURY S 1		9d. Date signed (Month, Day, Year) b / 9/ U 8	
Mg.		30. Name and address of person who completed cause of death (Item 23a) (Type V1777 31. Date filed (Month Pay, Year) 2008 32. Cagistrar's Signature	DIV- Strev St	HISTURY	n) 2/80/4	
State Registrar		ST. Date filed (MOTHER). I 2 2008				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2:39 a 06 09 08 Samuel E. Josephs /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner P.G. Cheverly Prince Georges Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Year) 12/07/1919 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. **№** M 2□ F 578-06-8124 Jamáica Director 88 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Beltsville Prince Georges Director MD 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 11300 Evans Trail #204 20705 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: Specify: Jamaican \$ 3 XWidowed 4 ☐ Divorced "natural", Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ' lealth and Mental Hygiene. m 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Carpenter 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hubert Josephs ၉ Rosa Laine Ramsev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 204) 05 19a. Informant's Name/Relationship (Type. Print) 11300 Evans Trail #204 Beltsville, Simone Josephs/daughter permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other i once. 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Washington Nat. 6/11/08 51 Other (Specify) Suitland, MD gnatur Funeral Servic 22. Name and Address of Facility 21 420 H Street BK Henry Funeral Chapel Inc. Wash DC 23a. Part 1. Enter the disease, or complications that careed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on cace line. Approximate Interval Between Onset and Death Immediate Cause (Final Sersis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events Due to (or as a consequence of): Examine Seizures burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the burial certificate be Physician/Medical Encephalopathy IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death The law requires that the death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed been 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? has autops, performed: 2 X No certificate 1 ☐ Yes 1 ☐ Yes 2 No : After this certification : After this certific Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 5 Pending investigation after death.

I Director: Af 1 Tyes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6/10/08 D0057636

Registrar

BJ

DHMH 17 Rev 1/2001

JUN 1 2 2008

State

Patricia Eben 3001 Hospital Dr. Cheverly, MD 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HWard 04 08 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wisomico the Lake xe/15bu pice castal If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year! 1 M 2 □ F Min 24-095 **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County notified at 1 Yes 2 No Director MD DICOMICO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ed other than "natural", or items 23a or event, the Medical Examiner must be in 86 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "naturar", or items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: Blac <u></u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary White Trir 29 Dolman, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Eden, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funcial Home a salisbuni MD 21801 Approximate Interval Between Onset and Death , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Enter the diseat heart failure. Immediate Cause (Fins END DRMANTIA **Physician** STACR resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performe 1∐ Yes 2 🔄 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 → No 1/2 Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation Injury 1 🗌 Yes 2 No 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.V 130701733 WARY ASTAL 31. Date filed (Month) D) (Year)

Registrar DHMH 17 Rev 1/2001

State

2008

08-04672
Brenda Peyton Jon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene es 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 17, 2008 0615 hrs Brenda Lee Medical Examiner Peyton Jones c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Princess Anne Somerset 11531 Drawbridge Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral Foreign Country) Months Days Hours Director 215-84-3967 M 2 F Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 10a, State 10b. County 1 Yes 2 No or items 23a or 28a-f show must be notified at once. rincess Director 10g, Citizen of What Country? 10e. Street and Numbe 11531 2185 Drawbr Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married 1 Never Married 2 No Yes Specify: Black Divorced If Yes, Give Year 1 Yes 2 No specify: Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", of
injury or other traumatic event, the Medical Examiner. 3 Widowed <u>م</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) al-Mart Inc. 17 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Garland Wise Be Patricio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ 11531 Drawbridge Rd. Princess Anne, MD 21853 ones/husbard larence 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 V Burial 2 Cremation 3 Removal from State 6/28/2008 Princess Anne, MD John Wesley Cemetery 4 Donation 5 Other Specify 917 W. Isabella St ture of Funeral Service Licensee Bennie Smith Funeral Home Salisbury, MD 21801 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only ope cause on each line. /Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Directors. That this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial -transit completely filled in 99 the funeral director, page 2 should be detached for use as the burial -transit Physician/Medical X UNPENDED AMENDED 27, perME, g881 7/11/08 TT Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown σ. Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be examiner? Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 ္ 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 1 Yes 2 No 5 Pending 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME June 18, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

Theodore M. King, Jr., MD.

31. Date filed (Month, 2 o 2008

Assistant Medical Examiner Registrar's Signature

111 Penn Street, Baltimore, MD 21201

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Mally d 2 sho the and the and 7 is me traume		19a. Informant's Name/Relationship Anthony F. Kadlul				1 Dogwood				. ,	'
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Physician		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each lir	ne.			tes	Dine	10		Interval Between Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At hor c. <i>(Specify,</i>	ne, farm,	street, factory, office		28f. Location City or To	(Street and N own, State)	lumber or Ru	ural Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20810 Certificate of Death 1. Decedent's Name (First, Middle, Last) Jane May Kramer 2. Date of Death JUME 10, ^D2/008 **Physician** 6:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Year | If Under 24 Hrs. Carroll Birthplace (State or Foreign Country) If Under 1 Date of Birth (Month, Day, Jan 05 Age (İn yrs. last birthday) **Funeral** Days Hours 1917 Months 1 □ M 2 F 212-36-7680 91 Yrs MD Director Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show notified 1 ☐ Yes 2 ☐ No Funeral Director MD Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 4008 McMullen Road 21787 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours after nd Mental Hygiene. marked other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Be Completed by Specify: 3 □Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi Charles Harvey Lapole Ida Mae Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trai 4008 McMullen Road William Kramer/son Taneytown, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial Pk 6/17/2008 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Liverise 22 Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 23a. Puri. Ent. rt. di me, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death Immediate Cause (Final Kenal **Physician** 1 week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Septicemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner due to (or as a consequence of) burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an rmea*?* 2**⊒-**No 1∐ Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WIL 2008 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHACKO 29 Stoner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 12 Registrar 2008

ORIGINAL

P.O. Box 68760.

Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month E 19, Day 2008 Year Physician 12:15 M Lease Ronald /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WMHS - MEMORIAL CAMPUS ALLEGANY CUMBERLAND 8. Date of Birth (Month, Day, Year) Jun 1, 1959 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 5. Social Security Number 6 Sex Country **Funeral** Months Days 1 M 2 □ F 49 216-80-8319 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Allegany Cumberland U∏Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 220 Carroll Street Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If filem 27 is marked other than "natural" ~ " once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married Ž☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 2 white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delores J. Valentine Lease Reuben T. Lease, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 220 Carroll Street Cumberland wife Kimberly Lease 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/20/2008 MD Cresaptown 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lical 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part. Ent. r e disease, or shock, or sart failure. List Immediate was (Final disease or condition resulting in death) Septic Physician /Medical Due to (or a a consequence of): epatic Failure Examiner Se uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit ute Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
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1 ☐ Yes 2 ☐ No 24a Was an 25. Was case referred to medical examiner?

1 Yes 2 No

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Division or Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours a

To the Funeral C

completely filled To the Hospital

nours after death.

neral Director: After this
filled in by the funeral d

State Registrar

Medical

4 ☐ Homicide

(Check only one)

31. Date filed (Month, Day,

29a. Certifier

OLAIDE AJAYI, M.D

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0066606

29d. Date signed (Month, Day, Year)

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

900 Seton Drive, Cumberland, Aide

MD 900 32. Registrar's Signature

			1- For amend #8 Per FR 13881	Manyland Bepa Cei	artment of He rtificate of D	ealth and M Death	ental Hyg	iene _{eg. No.} 2	2008	20812
	Physici	an	Decedent's Name (First, Middle, Last)				Date of Deat Month	th Day	Year	3. Time of Death
Į į	/Medic		Jean Gaston Ledford				June 1			8:55 p.m.
	Examir	ner	4a. Facility Name (If not institution, give street and numb	per)	4b. City, Town, or L	_ocation of Death		4c. Cou	unty of Death	
		Š.	39340 Ledford Drive		Clements	Killedes Od II.		St.	Mary's	
н	Funeral		11¥W 0□ F	. Age (In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day,	Year)	Coun	
H	Director		Usual Residence of Decedent	92 Yrs.			04 - 24 - 1	916	North	Carolina
	land ow at		10a. State 10b. County	10c. City, Town or Lo	cation		OT 2-1 1	J L U	10	Od. Inside City Limits
	Mary -f sh fied a	ģ	Maryland St. Mary's	Clements						1 ☐ Yes 2 X No
	r 28a	Director	10e. Street and Number	OTEMETES	10f. Zip Code		1	0g. Citizen	of What Coun	try?
	n with		39340 Ledford Drive		20624		T	nito d	l State	2
	d within 72 hours after death with the Maryland glene. Ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Deced	ent Ever in U.S. 13.	Was Decedent of His f Yes, specify Cuban	panic Origin? (Spe		14.	Race - America	an Indian,
و	after or Ite mine		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give	□ No	i res, specify Cuban I □ Yes 2 🕱 No	Specify:	nican, etc.)		Black, White,	etc.
5-0036	ours iral"	d by	3 ☐ Widowed 4 ☐ Divorced Year or Date	es:	I LI I ES ZIANO	оресну.		Sp	ecify: Whi	te
ر ر	72 h 'natu dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of workii	ng I	16b. Kind o	of Business/Ind	ustry
[7]	within 72 ene. than "nai	ם	Elementary/Secondary (0-12) College (1-4	or 5+)			-	_		
7	e filed v al Hygie other t vent, th		12 17. Father's Name (First, Middle, Last)	Land	Developer	18. Mother's Name			ruction	n
land		Be	, , , ,				,		,	
>	should by ad Menta	မ	Vance Talmadge Ledford 19a. Informant's Name/Relationship (Type, Print)	10h Mailin	g Address (Street ar	<u>Verdie Ka</u>				Codel
Mar	d2slthan Tisr traur								00.001	Code)
	1 an Heal em 2		Helen H. Ledford/Wife 20a. Method of Disposition		Ledford] sition (Name of natory or other place)				20624 on - City or To	vn State
õ	ages int of t; if it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from St	ate		i			•	,
altimore,	it. P.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Coensee	Charles M	emorial Co	em. 06/17	//2008 L	eonar	dtown,	Maryland
n n	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic e		Rollan Brinsfield,	Ir M00052 22	. Name and Address	Wood Pos	nsfield d Loor	Fune	ral Hom	e, P.A. 20650
	35		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each						WII eIII	Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ROSCIÓROTIC	40					Interval Between Onset and Death
	Examiner		Due to (or	as a consequence of):	71/				1	KEDNA-
	A 0.	P.	Sequentially list conditions, b. Due to (or	as a consequence of):						
	icate be executed physician and s the burial-transit	Examin	Sequer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
5	be executed ician and burial-transit	Exa		as a consequence of):						
8/PU	te be ysicia e bur	dical	d							
	tifical ig phy as th	ledi				*				
X Q	requires that the death certificate een signed by the attending physi nould be detached for use as the	Physician/Me	230. Was decedent pregnant	me pf pregnancy h 2 ☐ Fetal death 3 ☐	Ectopic pregnancy			23d.	Date of delive	ry
	e deal	sicis	1 Ves 2 No 4 Pregnar	nt at time of death 5 □	Other (specify)				Month	Day Year
٦ ک	at the by the	h.	9 Unknown							
'n	es th igned be de	by F	Part II. Other significant conditions contributing to dea			n in Part I.	23e. Did tob			e cause of death?
5	equir sen si ould	ed		70011			1 Ye	es a∏.M	fo 3 ☐ Proba	ably 4 □Unknown
Hecords	law r as be 2 sh	Completed					24a. Was ar		4b. Were autop	psy findings available appletion of cause of
r	The ate h	E O					perforr		death? 1 ☐ Yes	
N I G	sian; ertifica etor,	Be C	25. Was case referred to medical examiner?	-		26. Place of Death		-		
>	hysic his ce	To	1 Yes 2 1 No Hospital: 1 Interpretation	atient 2 ER/Outpatien	t 3 DOA Other	: 4 ☐ Nursing Hor	ne 512 Reside	nce 6 🗆	Other (Specify)
DIVISION OF	ng P		27. Manner of Death 28a. Date of 1 □ Natural 5 □ Pending (Month,	Injury 28b. Time of Day Year) Injury	28c. Injury a Work?	at 2	8d. Describe ho	w injury oc	curred	
20	endi eath. or: A	atic	2 Accident investigation		M 1 □ Ye	es 2 □ No				
Š	ter de trect	Certification:	determined 200. Flace U	f injury - At home, farm, stre , etc. <i>(Specify)</i>	eet, factory, office	2	28f. Location (St. City or Town		umber or Rural	Route Number,
ב	urs af					- 1				- 6
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the b 2 ✓ Medical Examiner: On the bas and manne	is of examination and/or inv	occurred at the time restigation, in my opi	e, date and place, a inion, death occurr	and due to the ca ed at the time, d	ause(s) and ate and pla	d manner as sta ace, and due to	ated. the cause(s)
	To th To th	Me	29b. Signature and title of certifier		29c. License		29		gned (Month, L	
)			1 /Lyru	MD	D	18096		6	-12-	08
			30. Name and address of person who completed cause	of death (Item 23a) (Type, I	Print)	205	1101	,		1000
			RATENDER S. Giv		ASSOCIA	100 11	rouge	UECZ	, NI.	10636.
	Sta Registr		JUN 1 6 2008	pistrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** LANG 9, 4:35 A. [™] JUNE MARJORIE KEMP В. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glade Valley Nursing Center Walkersville Frederick 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F 84 July 1, 1923 Ohio Director 274-26-5379 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No WV Jefferson Harpers Ferry Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 566 Persimmon Pear Lane 25425 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Specify white Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker - Artist own home 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event Be James T_AT Banfield Lucile Mahan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alexis Young / Daughter 566 Persimmon Pear La./Harpers Ferry, WV 25425 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 06/10/2008 | Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1100 N.Maple Ave./Brunswick, MD 2 dore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) weeks **Physician** /Medical Due to (or as a consequent a Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□ Unknown þ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **p** 3 Probably 4 Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy performed? Yes 22 No certificate 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA P this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760. P.0. Division or Vital Records,

3altimore, Maryland 21215-0036

or Attending Physician: To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Deved

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 Certifying Physiciap 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D4369)

Tore House

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

6-9-08

amended item #5/wico h.d./6-12-08/map Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:30 AM 09 08 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Hospice the at Lake Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**M** M 2□F Days 24/1931 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Accomac Director Parksley 10g. Citizen of What Country? 10e. Street and Number P.O. Box 1465 34. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No Maryland 21215-0036 Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operation 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cittle berta Grai 2 Henry injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau
once. yoursed White godson 1802 NW Street APLM Wilmington DE 19802 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 617108 Newark, DE Delaware Veterans 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service ticenses 917 W. ISAbella St. Bennie Smith Funeral Home Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fulfure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PROSTATE **Physician** CARCINOWA MRTASTATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☐ No Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3ENo 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Ampatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident **Director:** 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 124 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O BOX 1733 StrigBury ND COASTAC HOSPICA Cituaton withis 31. Date filed (Month, Day, Year) 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registra Reg. No. 2008 20815 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** June 8, 2008 6:10 P.M Roberto Liza-Menendez /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Health & Rehabilitation Center Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 231-85-7638 Director 1931 February 27, Peru Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evantment or other traumatic event, the Medical Evantment out the Indianal at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Prince William Virginia Manassas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6718 Leesa Dawn Court 20112 Peru Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Peruvian ģ Specify: Hispanic 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Minister Foreign Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roberto Liza-Carrillo Aurelia Menendez viuda de Liza ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6718 Leesa Dawn Court Manassas, Virginia 20112 Yolanda Clark- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Pleasen brender) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🛱 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-13-2008 Annandale, Virginia Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Everly Community Funeral Care m61455 6161 Leesburg Pike, Falls Church, VA 22044 23a. Part1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) MULTIPLE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 12No 1 ☐ Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🛱 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) san uns 20057124 C/10/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, Suite 201 Rockville, MD 20850 Truong Bao, M.D. 31. Date filed (Month, Day, Year) State JUN 1 3 2008 Registrar

Amended Item 7 per F.D. & Item 26 per Phy. 06/10/2008 Carroll Co., wjl & Item 31 per CCHDPlease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 **Physician** 2008 10:48 PM June Robert Eugene Lynn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Westminster Carroll Carroll Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 5, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1933 1XM 2□ F Pennsylvania 74 73 200-24-7679 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. An anti- if item 27 is marked other than "natural", or items 23a or 28a-f show anti- if item 27 is marked other than "natural", or items 25a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at ia or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Westminster Maryland Carroll Director 1 TYes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 822 Wisteria Dr. "natural", or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 52 Yes 2 □ No 1950— If Yes, Give Year or Dates: 1970 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **CPO** United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Lynn Esther Wolfred 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 Is
any Injury or other trau 822 Wisteria Dr., Westminster, MD 21157 Medora E. Lynn/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 06/07/08 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State Carroll Cremations, Hampstead, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Prints After ally Home & Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardial ntarct **Physician** min /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tor as a consequence of Physician/Medical Examine requires that the death certificate be executed physician and strans Due to (or as a consequence of): P.O. Box 68760, the as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ sign be (1 TYes 2 No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performed certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[7] No 1 🔲 Inpatient Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral director. this 27. Many of Death 28a. Date of Injury (Month, Day Y 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number WIZ SXIVA cause of death (Item 23a) (Type, Print) Drive Ste C Westminster, MD 21157 Malco 410 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** JAMES LUTHER 2008 5, 18:58PM June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cecil Union Hospital Elkton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ★M 2 ☐ F 103-36-3722 62 Director 12/14/1945 Riverhead, NY Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at DE New Castle Middletown 1 □ Yes 2X XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19709 U.S.A. 909 South Scott Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? → Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 XNo Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Is marked other than aumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Line Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Barns Allen Luther ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane L. Luther/Wife 909 S. Scott Street, Middletown, DE 19709 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or o once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State United Crematory \$rv. 6/7/08 Newark, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
DANIELS & HUTCHISON FUNERAL HOME LLC
212 N. Broad St., Middletown, DE 19709 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Intractable 2 Lours /Medical Due to (or as a consequence of): Examiner Ulmonery Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hodalcias 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 10 2 ER/Outpatient 3 DOA 27. Manner of Death

1 → Natural

2 □ Accident illed in by the funeral 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director; 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) in my 00055/90 4+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Hospital 106 Bow St Elkton mo 21921 Altred A UrD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 0 9 2008 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: ours after death.

neral Director: A
filled in by the fu within 24 hours a

To the Funeral I

Medical

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

Mahesha

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

08-04668 Brandon H. Larkin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 20819

		1-For State	ertificate o	f Death		Reg.	No.	00 2001			
Physici		Registrar 1. Decedent's Name (First, Middle,Last)				2. Date of Death	ay Yaar	3. Time of Death			
edical Exami	ner	Brandon Harris La	rkin			June 17, 200	08	0620 hrs			
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	1	4c. County of D	eath			
		6145 Bumpy Oak Road		La Plata			Charles				
Funeral Director		218-19-9740 _{1XM 2} F	s. last birthday) 21 _{Yr}	If Under 1 Year Months Day s.				Birthplace (State or Foreign Country) Maryland			
any		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ity, Town or Loca	ition				10d. Inside City Limits			
<u>*</u> *			La Plat					1 Yes 2 XNo			
Maryland 28a-f show	tor	MD Charles 1 10e. Street and Number	ua Fiat	10f. Zip Code	-	10a.	. Citizen of What	Country?			
e Mai or 28	Director			2064	16		U.S.				
with the Maryland ns 23a or 28a-f sho	al D	6145 Bumpy Oak Road 11. Marital Status 12. Was Decedent Ever in	IIS TIS W	as Decedent of His		necify Yes or No-		merican Indian, Black,			
ath w	Funeral	1 V Never Married 2 Married Armed Forces?	If '	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	White, et				
ter de		1 Yes 2 X No	1	Yes 2 X No	specify:		Specify:	White			
urs af tural	d by	15. Decedent's Education (Specify only highest grade completed)) 16a. Decede	nt's Usual Occupa	tion (Give kind of		6b. Kind of Busine	ess/Industry			
72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	during r	nost of working life	e. DO NOT use ref	i					
036 ithin ne.	ompleted	12	Elect	rician	Helper	[1	Electri	cal Co.			
21215-0036 Mult be filed within 72 hours after death with the Maryland Maryland Hygiene. marked other than "natural", or items 23a or 28a-f 5te ic event, the Medical Examiner must be notified at once	ပ	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma		,			
121 d be fi ental arked	Be	Robert Taylor	ta Lark								
D 21 should I and Mei 7 is mai	2	19a. Informant's Name/Relationship (Type, Print)		,		Rural Route Number	•				
조 등 등 등 등		Lauren M. Davey/Sister 20a. Method of Disposition 20		sition (Name of ce		Glen Bur ne 2	20c. Location - Cit				
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State	crematory or o								
ti Pag tmen tmen rtant	-		11 Cour	ity Crm	tn. 19	,2008	Sykesvi	rvice, P.A.			
Baltimore permit. Pages 1 Department of I Important: If i		21. Signature of Funeral Service Licensee				Ave.,La					
Physician		23a. Part I. Enter the disease, or complications that caused the dea						Approximate Interval Between Onset and			
/Medical		failure. List only one cause on each line. Immediata Cause (Final disease a. Farming in the Cause of the Cause (Final disease a. Farming in the Cause of the Cau									
Examiner		or condition resulting in death) Due to (or as a consequence of):									
	_	Sequentially list conditions, b. Pue to /cr as a consequence of):									
	in	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause									
ا بر م نب	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
30x 68760, death certificate be executed to attending physician and foo use as the burial - transit		d. X UNPENDED AMENDED 200 f. TO									
760, cate be ex physician he burial	Medical	23a,21,20a-1,4		6/27/08 TI	1		23d. Date of de	liven			
876 liffcat ng ph		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of prediction of the prediction of t		etal death 3	Ectopic pregr	ancy	Month Month	Day Year			
Box 687 death certific the attending of for use as the	icia	past 12 months? 4 Pregnant at time of	C de adh	Other (Specify)							
BO) le deatl the att	Physician	1 Yes 2 No 9 Unknown 9 Unknown			D	Did tobe	and the contribut	te to the cause of death?			
cords, P.O. Be law requires that the de has been signed by the		Part II. Other significant conditions contributing to death but no	ot resulting in the	underlying cause	given in Part I.			Probably 4 Unknown			
S, Fquires en sign	Completed by		 			24a, Was an		re autopsy findings available			
of Vital Records, ng Physician: The law requir (After this certificate has been someral director, page 2 should	ple					autopsy perform		r to completion of cause of th?			
Rec The licate	Son					1 ✓ Yes 2		Yes 2 No			
Vital Rec hysician: The this certificate I director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2			e of Death (Check Other: Nurs			211 0			
Physical direction	ဥ	1 Yes 2 No Inpatient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatier 28b. Time of		ury at Work?	ing Home 5 Re	esidence 6	Other: Scene			
~ = . ~ = I	ü.	1 Natural 5 Pending (Month, Day, Year)	200. Time of		Yes 2 X No	unk	,,				
ivision or Attendath after death Director:	cati	2 Accident Investigation Fm 6/17/2008	thorne farm str	am			eet and Number of	or Rural Route Number, City			
Division fal or Attendir rs after death. al Director: A	Certification:	Suicide 6 A Could not be				or Town, Sta	te)	A Plata, MD			
D 110spital 24 hours Funeral etely filled		4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my know	ledge, death occi	urred at the time, o	tate and place, an						
Divisior To the Hospital or Attency within 24 hours after death To the Foneral Director:	Medical	one) 2 Medical Examiner: On the basis of examinatio and manner stated.	n and/or investig	ation, in my opinio	n, death occurred	at the time, date ar	nd place, and due	to the cause(s)			
F B F S	Me	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed	(Month, Day, Year)			
		anel		0.C	.M.E.		June 17, 200	8			
		30. Name and address of person who completed cause of death (It			10 4						
		Ana Rubio MD. Assistant Medical Examiner		Street, Baltim	ore, MD 2120)1					
St		31. Date filed (Month, Day, Year) 32. Registrar's Sign	pature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 20820

Charles M. Mahone	1-	For State	ate of	Maryla	and / Depa <i>Cei</i>	artment o			Menta	al Hyg		eg. No.	200	8	20821
Physician/		egistrar . Decedent's Name (First, Midd	e,Last)		-			· · · · · ·		2.	Date of Dea	ith		3. Time	of Death
" al Examiner		Charles M. Mahoney									Month June 21, 1	Day 2008	Year	0102	2 hrs
4.	4	a. Facility Name (if not institution	-						ocation of l	Death			County of Death		
		Westbound Route 50	East of	Church			Bow						nce George		
Funeral	5	. Social Security Number	6. Sex		7. Age (In yrs. I	ast birthday)	If Un	ths Days	If Under 2	24Hrs. Min.	8. Date of Bi	rth(MM/DI	D/YYYY) 9. Bir Foreig	in.	
Director		577-74-3800	1 X M	2F		54	rs.	Days	Tiodis	tviiti.	Jan.	5,19	54 Was	STI's	DC
	-	Isual Residence of Decedent			T40- 6:4:	, Town or Loc	ation							10d Inc	ide City Limits
w any	'	0a. State 10b. County			Toc. City										es 2 No
-f she	L	DC				Wasl	ning	code				to- Cities	en of What Cou		- L
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th the rotific and D		1505 Fort Da			SE cedent Ever in U	6 40 1	Van Daas		020	2 / 520	cify Yes or No		ted St		
r death with or items 23 must be no		Marital Status Never Married 2 X M		Armed F	orces?				Mexican, F			J- 1	White, etc.	ican muia	II, DIACK,
er death ', or ite r must Fun	:		1	Yes Yes, Give Yea	2 X No	1	Yes	2 X No	specify:			s	pecify: Bla	ck	
rrs aff	ĩ⊢	15. Decedent's Education (Spe	10	Dates:		16a. Deced				nd of wo	rk done		nd of Business/		
.0036 within 72 hour ligiting. Wether than "natu line than "natu line than "natu line than completed	H	Elementary/Secondary (0-12)		College (1-4 or 5+)	during	most of w	orking life.	DO NOT us	se retire	d)				
ne.		12	- 1				M	aint	enand	ce		ļ	Priv	ate	
5-0 led w other other Col)	7. Father's Name (First, Middle	Last)					1	8.Mother's	Name (F	irst, Middle,	Maiden S	urname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	ìL	Unk.							Bark	oara	a Ma	hone	У		
MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	٠.	9a. Informant's Name/Relations				19b. Mai	ing Addre	ss (Street	avis	er or Ru St.	ral Route Nu , SE	mber, City	or Town, State	e, Zip Cod	le) ·
MD and 2 sho saith and 27 is raumati	H	Rose H. Maho 20a. Method of Disposition	ney	/wife	20h	Was Place of Disp	ning	ton,	DC netery	200) <u>20</u>	20c. Lo	ocation - City or	Town, St	ate
Ore Ses 1 a of He of Her t		1 X Burial 2 Crematio	3 🗌	Removal fi	rom State	crematory or	other plac	e)							
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite Important or other trainings or other tr	_	4 Donation 5 Other S	ecify:		Res	surre					3/08		lintor		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by F	'	21 Signature of Funeral Service	Licensee	An	,	ľ			of Facility				wards		
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Medical		Vailure. List only one cause	on each	_{line.} ultiple Inj										Betwe	een Onset and Death
≟xaminer		Immediate Cause (Final disease or condition resulting in death)			a consequence of	of):								1	
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led nsit		Disease or injury that initiated events resulting in death) Last	E: Du	e to (or as	a consequence	of):									
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60, 62 e executed e be executed burial - transit ledical Exe		UNPENDED		AMENDED								-			
68760, certificate be e miding physicia see as the buria cian/Medi		F FEMALE: 3b. Was decedent pregnant in t			outcome of pre				Fatania				. Date of deliver Month	*	Year
certif		past 12 months?		1 Live	birth nant at time of d	eath 5	Fetal deal Other (St		Ectopic	pregnan	СУ	1 '	MOHUI	Day	Teal
b. Box 6876 the death certificate the attending phy or the attending phy ched for use as the Physician/M	2	1 Yes 2 No 9 Ur	known	9 Unkn	iown	0	Outer (9								
cords, P.O. Box 6876 law requires that the death certificate has been signed by the attending phy 2.2 should be detached for use as the Universe as the Univer		Part II. Other significant condi	ions co	ontributing t	to death but not	resulting in th	e underlyi	ng cause g	iven in Par	t I.			se contribute to		
ires that signed 1 be deti											1	h-pilana.	No 3 Pro		h-man'
of Vital Records, and Physician: The law requirement is certificate has been significate that the control of th											24a. Wa auto	s an opsy			idings available on of cause of
Recc The lav cate has	ŧI.										per 1 ✔ Yes	ormed?	death?	'es	2 No
tal Rection: The certificate ector, page		25. Was case referred to medical	ı					26.Place	of Death (Check or	nly one)				
Vital ysician this certi director	١.	examiner? 1 ✓ Yes 2 No	Hos	pital:	Inpatient 2	ER/Outpati	ent 3	DOA	Other ₄	Nursing	Home 5	Residen	nce 6 🗸 Othe	er: Scene	
of ng Ph After I Uneral		27. Manner of Death		28a. Date	e of Injury h, Day Year) , 2008	28b. Time	of Injury		ry at Work?	l In	28d. Describe				
Division o spital or Attending nours after death. neral Director: Aft rilled in by the func Certification:			ding stigation		, 2008	0010 hrs		1`	res 2 ✓ I	No	- data				
ivis or A Direc Jin by		3 Suicide 6 Cou	ld not be	28e. Pla	ce of Injury - At I		treet, facto	ory, office b	uilding, etc						e Number, City d, Bowie, MD
Divisor papies or papies or process of the process	5	4 Homicide	rmined		Interstate										d, Bowle, MD
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the befolical Certification: To Be Completed by Physician/Me	5	Check only Certifying r	hysician miner: 0	: To the be n the basis	est of my knowle of examination	dge, death oo and/or invest	curred at t gation, in	the time, da my opinion	ate and place , death occ	ce, and curred at	lue to the ca the time, dat	use(s) and e and plad	d manner as sta ce, and due to t	ited. he cause	(s)
To the He within 24 To the Fu complete!	2	29b. Signature and title of certifi	aı	nd manner	stated.			29c. Licens					Date signed (M		
		110	D	. ()	(0000		[O.C.					21, 2008	. –,	,
	L	30. Name and address of perso	, IV	moleted car	T UUU	m 23a)						1			
10		Margarita Korell MD.			edical Exami		Penn S	Street, B	altimore,	MD 2	1201				
State	е	31. Date filed (Month, Day, Year	•••	82. F	Registrar's Signa	ture	8 0								
Registra	r	111N 2 6 2	บบช	Oling.	100 15	1	1								

		-	For State Registrar	State of Ma	ryiand	Cer	tificate of	neann and i Death	менан пу	Glen Reg. N	2008	3 20821	
Phys	icia	n	1. Decedent's Name (First, Middle, Las						2. Date of De Month	D	ay Year	3. Time of Death	
/Me	dica	11	FRANCIS EGGENE MOSER							c. County of Dea	8:35 A ^M		
Exar	nine	r ÷	FREDERICK MEMOR		[AL		FREDE				FREDER		
Funer Direct			219-30-2370	en and	(In yrs. las 76	t birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug. 9,	th a <i>y,</i> Yea 19	9. Bir 31 Mai	thplace (State or Foreign bunty) cyland	
land ow		-	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits	
ite; Midifylding ZIZIO-000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		į	Maryland Freder	ick	Mye	rsvil	le					1 □Yes 2√ No	
		Funeral Director	10e. Street and Number				10f. Zip Code				itizen of What C	ountry?	
		e la	10818 Harp Hill R	oad 12. Was Decedent E	ver in IIS	13 \	21773	lispanic Origin? (S	necify Ves or No		ISA 14. Race - Ame	erican Indian.	
		à	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates: 5	0		Vas Decedent of H fYes, specify Cuba I∐Yes 2∏ No	Specify:	o Rican, etc.)		Black, Whi		
72 hc 72 hc "natur dical		eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. De		cedent's Usual Occupation ve kind of work done during most of work c. DO NOT use retired)		rking	16b.	Kind of Business	/Industry	
within ene.		Completed	Elementary/Secondary (0-12) College (1-4or 5+) Grammer College (1-4or 5+)					a)		D.	airy Far	m	
Hygi Hygi other	1	e B	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle	, Maide	ən Surname)		
Lal ylallu ZIZI 2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me		0	Roger Jacob Mo	oser				Edna	Poffenb	erg	er		
2 sho			19a. Informant's Name/Relationship	, ,			- '	Address (Street and Number or Rural Route Harp Hill Road, Myer:					
1 and 2 Health Gem 27 is			Grace M. Moser /	wile			sition (Name of natory or other place		Date		Location - City or		
Page nent o			1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)	<i>(</i>)		ssnicl		renJune		Му	•	, Maryland	
pant. Departri	ouce		21. Signature of Funeral Service Lice	ests		1	icketts F	•			ville, M		
			23a. Part1 Enter the di rase, i com shoot, or leart failure. List only Immediate Cause (Final	olications that caused one cause on each lin		Do not ente	er the mode of dyir					Approximate Interval Between Onset and Death	
Physicia /Medic			disease or condition resulting in death)	a. LARGE Due to (or as a	consequer	nce of):	הספושה					3 0046	
Examin			Sequentially list conditions. CHANGE ORGANIZATION PROMINENT PROMINENT DISEASE - SEVENCE									10 m.	
Ca ts	-	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequer	nce of):							
xecut rand al-tran		xan	that initiated events resulting in death) Last	c Due to (or as a	consequer	nce of):							
rifficate be executed by physician and as the burial-transit		edical	L _d										
rtificat ng phy as th			IF FEMALE:										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							23d. Date of de Month	livery Day Year	
s that ned b	i	by Pr									use contribute to the cause of death?		
w requires to been signer should be									1 🔀	Yes	2 No 3 F	robably 4 Unknown	
vician: The law recentificate has be rector, page 2 sh		Completed							24a. Was auto perf 1∐ Yes		prior to death?	utopsy findings available completion of cause of s 2 □ No	
VICAL Ician: Tertificat ector, p		Re	25. Was case referred to medical examiner?	Hospital: ,,			t 3DDOA Oth	26. Place of De					
Phys rthis ral dir		<u> </u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	у 2	R/Outpatien 8b. Time of	28c. Inju	ry at	lome 5 ☐ Res 28d. Describe		6 ☐Other (Sp.	ecify)	
nding Ith. r: Afte		tion	1 Natural 5 ☐ Pending investigation	(Month, Day	Year)	Injury	Work? M 1 ☐ Yes 2 ☐ No			in the state of th			
I or Attending after death. Director: After din by the fune		Certification:	3 Suicide 6 Could not be 4 Homicide determined	ry - At hom- . (Specify)	at home, farm, street, factory, office 28f. Location City or					ion (Street and Number or Rural Route Number, or Town, State)			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.		Medical			ace, and due to the cause(s) and manner as stated. accurred at the time, date and place, and due to the cause(s)								
To th withir To th		M	29b. Signature and title of certifier					29c. License number			29d. Date signed (Month, Day, Year)		
	Neil Warawdeka, ms D47611 June 22,												
4			30. Name and address of person who MELL WAYNERS (Month, Day, Year) JUN 2 6 2008	completed cause of de	eath (Item 2	3a) (Type,	Ave SJ.	TR 204	FREDER	اديد	mo zi	702	
Reg	Stat istra		31. Date filed (Month, Day, Year) JUN 2 6 2008	32. Registra	r's Sinnatu	GOBA							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 18 A^M Manspeaker 2008 Emma 5:20 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Golden Living Center Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Jan. 14, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Year) 1924 1 ☐ M 2 💢 F Maryland 84 Director 215-18-1265 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1X Yes 2 □ No Director MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or "natural", or items 23a 21740 U.S.A. 115 N Jonathan St. Apt. 301 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or itel 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☑ Widowed 4 ☐ Divorced White of Health and Mental Hygiene.
Item 27 Is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Slick Vada E. Moats 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. Slick/Son 9157 Williamsport Pike, Falling Waters, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 6/20/2008 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Men 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Inflammatory Bowel tobsease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner lactrolyte imbalance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit 0 di Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1□ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ression 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed this certificate 20 No Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifice filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient ٥ 2 ☐ ER/Outpatient 3∏ DQA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Qn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 Dr. ALI MD

State Registrar

DHMH 17 Rev 1/2001

Dr. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andalub Au' BG 8 368 MILL ST. Hagerstown Andaleeb 32. Registrar's Signature

ORIGINAL

D66116

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Ma	-	partment of			-		0.0	00000		
			1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death									Reg. No. 2008 2082			
1	Physici	Sician Evelyn Scott McDaniel										Year	12:15 P M		
	/Medic		the City of the standard and the City of City									of Death			
	Examin	er	45817 Aberdeen Lane Valley Lee								St. Mary's				
	Funeral		Social Security Number	6. Sex	7. Age	(In yrs. last birtho		r If Unde	r 24 Hrs.	8. Date of Bir	th	9. Birthp	lace (State or Foreign		
г	Director		231-12-2169	1□M 2対F 84			34 Yrs. Months Days			(Month, Da Septembe	er 3, 1923	Cour Virg			
	<u>p</u>		Usual Residence of Decedent			40. 00. 7									
	arylar show d at	_	10a. State 10b. County			10c. City, Town o						1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	ne Ma 18a-f	Director		Mary's				y Lee							
	with the		10e. Street and Number				10f. Zip Code					0g. Citizen of What Country?			
	sath v	Funeral	45817 Aberdeen	Lane 12. Was Dec	odent E	ver in IIS	20692		rigin? (Co.	agifu Van ar Na	US 14 Bace		an Indian,		
	item	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed F	orces?	ver in 0.3.	 Was Decedent of the second of the	uban, Mexica	an, Puerto	Rican, etc.)	Black	, White,			
36	ırs af Il", or xami	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive		1 ☐ Yes 2 🖾 N	o <i>Specify</i>	<i>'</i> :		Specify:	Wh:	ite		
21215-0036	2 hou atura ical E	ted	15. Deceden	's Education	16a. De	ecedent's Usual Occ	upation			16b. Kind of Business/Industry					
2	hin 7 e. an "n Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	live kind of work dor fe. DO NOT use reti	ie during mo red)	st of work	ing								
7	od wil	Son	Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide							Healt	h Car	e			
Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle,	Last)				18. Moth	er's Name	e (First, Middle	, Maiden Surname	e)			
yla	ould Men arke	P	Raleigh Terry							Scott					
Jar	12 sh h and 7 Is m raum		19a. Informant's Name/Relations				ailing Address (Stre					State, Zip	Code)		
e,	1 and Healt em 2 ther		Sheila Simms / Daug	ghter			O Christian sposition (Name of	a Lane		den, MD 2	20c. Location - (City or To	nun Stato		
more,	ages nt of t: If It		1 ☑ Burial 2 ☐ Cremation		State	cemetery,	crematory or other p		June	17,	Valley Le	•	,		
altin	artme artme ortani injury		4 □ Donation 5 □ Other (S			DE: 00018	ge's Catholi Cemeter	y ! Iress of Faci		2008 tinglev=(Home, P.A.		
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evonce.		Muchaelok	Hardy	ie		P.O. Box 27						11111		
37	-		23a. Part I. Enter the disease, dr shock, or heart failure. List	complications that	caused t	he death. Do not	enter the mode of d	ying, such a	s cardiac	or respiratory a	rrest,		Approximate Interval Between		
4	Physician		Immediate Cause (Final									Onset and Death			
	/Medical		resulting in death)	Due to	(or a	consequence of):	arcer								
	Examiner		Sequentially list conditions. b.												
	pe sit	ine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to	(or as a	consequence of):									
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_	ificate g phy as the	edical		0.											
Box	death certifi attending I for use as	Σ	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou		f pregnancy	2 Tetonia assessa				23d. Date	of delive	ery		
	deat le atte	Physician/M	in the past 12 months? 1 □ Yes 2 □ No		nant at t	ime of death	3 □Ectopic pregnar 5 □ Other (specify)				Mon	ith	Day Year		
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Ś	The law requires that the death certif the has been signed by the attending bage 2 should be detached for use as	by I	Part II. Other significant condition	ns contributing to o	death but	not resulting in th	e underlying cause i	given in Part	I.				ne cause of death?		
Records,	w require been significant	Completed								1 🗆	Yes 2 No	3 PIOL	ably 4 Unknown		
ခိုင	e law has b	nple								24a. Was	psy p	rior to co	psy findings available mpletion of cause of		
										1□ Yes		eath? □ Yes	2□No		
Viital	Physician: this certificaral director, p	Be	25. Was case referred to medical examiner?	Hospital:				other:		n (Check only o	_	-			
ō	Phy this	- T	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatien of Injury	28b. Tim	THEIR SELDON	4 ⊔ N			dence 6 Othe		y)		
on	Attending I r death. ector: After by the funer	tion	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investig	(Moi	nth, Day	Year) Inju		ork? ∐Yes 2.⊑			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
Division or	l or Attend after death. Director: /	ifica	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	pad Zoe. Plac	e of injur	y - At home, farm (Specify)	street, factory, offic	e		28f. Location (Street and Numbe	r or Rura	l Route Number,		
	tal or A	Certification:	4 - Hothleide	build	iling, etc.	(Specify)				City or To	wn, State)				
	To the Hospital or Within 24 hours afte) To the Funeral Dir completely filled in I	edical	29a. Certifier 1 € ertifyin (Check only one) 2 Medical	Examiner: On the	e best of basis of e nner state	examination and/o	eath occurred at the or investigation, in m	time, date a y opinion, de	ind place, eath occur	and due to the red at the time,	cause(s) and mar , date and place, a	ner as s ind due to	tated. the cause(s)		
	To the To the complet	Me	29b. Signature and title of certifie	7			29c. Lice	nse number			29d. Date signed	(Month,	Day, Year)		
)	D.		AXA	S			D	5421	4		60 13	3/08	>		
	TU		30. Name and address of person	who completed cau	se of dea	ath (Item 23a) (Ty	pe, Print)	ree N		0.4	1	1	ND 20636		
			31. Date filed (Month, Day, Year)	rupta	MD Benstrar	's Signature	35 Th	ree M	otch	o'cl	tollywo	Est, 1	ND 20636		
	Sta Registr			6 2008	Straf	o oliginature	Sol				J				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend#10e Per FH G881 7/09/08 JH Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE 8 2008 DUDLEY D. MAHON 11:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE NURSING HOME MONTGOMERY SILVER SPRING If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 □ M 2 □ F Director 215-08-7456 APRIL 24 1924 BARBADOS Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County MONTGOMERY 1 Tyes 2 □ No Director MD BURTONSVILLE #13 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 3909 BLACK BURN LANE #813 20866 USA "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 ☐ X\\\
If Yes, Give X\\
Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2√ ☐ No Specify. Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation other traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 YRS ASSISTANT MANAGER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 EDGAR MAHON GWENDOLINE HAREWOOD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERYL HOLDER/DAUGHTER 7523 MCWHORTER PL. # 303 ANNADALE, VIRGINIA 22003 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any Injury or ± ö RIVERDALE CREMATORY 6/13/2008 RIVERDALE, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): mark disease or condition resulting in death) LUNG WITH METASTASIS /Medical Examiner Sequentially list conditions Physician/Medical Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Veal Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign be 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ②☐ No 24a. Was an certificate has autopsy 2 No Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 5 ☐ Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No death. 2 Accident the 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one)

ompletely within 24

S.M. NAYAR 31. Date filed (Month, Day, Year) JUN 1 3 2008

29b. Signature and title of certifier

3717 -MD 3810 AVE 32. Registrar's Signat

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D-17874

COTTAGE CITY

29d. Date signed (Month, Day, Year)

MD

6-9-2008

20722

			1 - Fogmend #19b &29d Per FH &PHY 888 P	tificate of Death	Mental Hygiei Reg.	ne № 2002 20225
	Physici	A an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
13	Pnysici Medic		ELSIE MAE McLAURIN			5, 2008 1510 M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death
July 1		Н	PRINCE GEORGE'S HOSPITAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	CHEVERLY If Under 1 Year If Under 24 Hrs		PRINCE GEORGE'S
	Funeral Director		577-42-1290 1□M 2\(\overline{\text{Y}}\)F 75 Yrs.	Months Days Hours Min.	(Month, Day, Ye.	
	D		Usual Residence of Decedent		1,01.), 1,	
	arylar show	-	10a. State 10b. County 10c. City, Town or Loc Maryland Prince Georges Capitol	Heights		10d. Inside City Limits 1 □ Yes 2 □ No
	the M 28a-f notifie	Director	10e. Street and Number	10f. Zip Code	100	Citizen of What Country?
	with 3a or t be	Ö	312 Possum Ct.	20743		nited States
	death ms 2 r mus	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. It was 23 or 28a-f show tem 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No	Yes, specify Cuban, Mexican, Puer Yes 2 No Specify:	to Rican, etc.)	Black, White, etc. Specify:Black
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2	filed w Hygie ther t	S	12 Supp	oly Specialist	me (First, Middle, Maid	Government
au	d be tental ted or	To Be	Paul Gordon, Sr.		ice Briscoe	,
Maryland	2 should be filed v and Mental Hygie is marked other t aumatic event, th	-		Address (Street and Number or Ri		
	1 and 2 Health a tem 27 is			Parker Way #556 I	etroit, Mi	48214
Baltimore,	Pages 1 and of Hest Int: If Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crem	ition (Name of atory or other place)	Date 20c.	Location - City or Town, State
Ē	t. Pag tment tant: ijury d		4 □Donation 5 □ Other (Specify) Cedar I		3/2008 Su	itland, Md.
Ba	permit. Pages Department of Important: If II any injury or once.		21. Signature of Funeral Service Licentes 22.	Name and Address of Facility Lexander, S. Pope 538 Mariboro Pik	ė/Forėstvi	11e, Md. 20747
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardia	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Jatu Curdia	c arrhythn	iia	Onset and Death
	Examiner		Due to (or as a consequence of):	U		
	4	ē	Sequentially list conditions, if any, leading to infinediate b. Due to (or as a consequence of).			
	cuted id ansit	Examin	If any, leading to infinediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.			
Ď,	e exe ian ar ırial-tı	Ex	resulting in death) Last Due to (or as a consequence of):			
8760,	icate be executed physician and s the burial-transit	dical	d			
9		/Me	IF FEMALE: 23b Was deceded grapher 23c. If yes, outcome pf pregnancy			
X Q Q	e law requires that the death certif has been signed by the attending je 2 should be detached for use as	Physician/Me	in the past 12 months?	Ectopic pregnancy Other <i>(specifv)</i>		23d. Date of delivery Month Day Year
j.	the d	nysi	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown	Carlot (oposity)		
Ω̈́,	ss that gned to e dets	by P	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
Records,	equire en sig ould b	edk			1 ☐ Yes	2 No 3 Probably 4 XUnknown
ပ္	aw dis	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	ate T	Con			performed 1∐ Yes 2 🛣	? death?
\ Iga	Physician; The la	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Oak	ath Check onl one	
0	Phy this al di	٦.	1 ☐ Yes 2 📉 No		lome 5 ☐ Residence	6 Other (Specify)
SION	th. : Afte	tion	1 Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	20d. Describe now ii	ijury occurred
N N S	or Atter fter dea Director in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier (Check only gradient) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inv	occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.
	the hin 24 the F	/ledical	and manner stated.			
	No. of	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
^	69	-	30. Name and address of person who completed cause of death (Item 23a) (Type, F	1 DO8951	70	nay or seco
2	1		CHARY LETTLE, MD 3001 HO	SPITAL DR	CHEVE	RLY, MD 20785
	Sta	te ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

08-04462 Janet Helen Noonan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008 20826

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 10, 2008 Month 1021 hrs Medical Examiner Janet Helen Noonan 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Gaithersburg Montgomery 8125 Seneca View Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months CountryMissouri Director 488-30-5679 1931 1 M 2 XF March 8. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Maryland Montgomery Gaithersburg permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8125 Seneca View Drive 20882 U.S.A. 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes 4 Divorced If Yes, Give Year or Dates: White 1 Yes 2 X No specify: Specify: 3 XWidowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cierport Be Helen Amos Roth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Erin T. Zezzo - Daughter 3570 Wells Ford Lane, Doylestown, <u>Pennsylvania</u> 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition fimore, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State All Souls Cemetery 6/16/08 Germantown, Maryland 4 Donation 5 Other Specify 21. Signature of Funeral Sauce Licens 22. Name and Address of Facility Molesworth-Williams P.A., 26401 Ridge Road, Damascu Funeral Home 20872 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a. Congestive Heart Failure Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED attending physician for use as the burial UNPENDED Box 68760. 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Day Year Month Fetal death 3 Ectopic pregnancy 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 V No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ 1 Yes 2 No 3 Probably 4 V Unknown Δ. Diabetes mellitus Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? this certificate has performed? ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) nr Attending Physician: the funeral director, 25. Was case referred to medical of Vital Be Other: Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural Division 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Pending. Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. June 11, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) State 2008 JUN 1 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** *michael* Pittsnogle 2008 12:08 /Medical Keith June 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 638 N. Prospect St. Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours **Ж**□ M 2□ F Director 56 4,1951 219-52-1510 West Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Md. Washington Hagerstown 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 638 N. Prospect St. 21740 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 **X**No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner & Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William D. Pittsnogle Alma L. Western P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia K. Pittsnogle (Wife) 638 N. Prospect St. Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 27. 1 ☐ Burlal 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home MO1414 Smithsburg, Md. 21783 ce Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner be executed burial-tran Due to (or as a consequence of): physician the l as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f o. 9□Unknown 9 Unknown ۵ sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 1∐ Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Injury 1 Natural 5 Pending 1 ∏Yes 2 ∏No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 medical layer Hegenstown MO MCCo 1 cheel Neck 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 6 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** P^{M} 2008 Jean Michelle Pippin June 21 1832 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil 55 Elk Chase Drive E1kton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF Director 214-76-0600 36 July 3, 1971 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits d other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ▼Yes 2 No Director Ceci1 E1kton Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 55 Elk Chase Drive 21921 United States death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No 2 Specify: 3 Widowed 4 NDivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Ms College (1-4or 5+) Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James William Pippin Lana Guiberson 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Pippin/Father 12 Avalon Avenue, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 26 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 2008 Union, MD 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ludden **Physician** /Medical Due to (or as a consequence of): Examiner where if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last De to (or as a consequence of): Examiner sician and burial-transit the death certificate be executed BERY ENSION Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician JOCAL SEGMENTAL Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To the Hospita. ...
within 24 hours after death.

To the Funeral Director: After this ce Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🖼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1+0037636 06-24-2008 Surnix 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTIN F. GAVIN, DU 4923 OGLETOWN-STANTON Rd STEZOO NEWARK DE 19713 31. Date filed (Month, Day, Year) 32. Registrar's Spnature State JUN 2 6 2008

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year June 13, Kathleen 1:45p Patricia Peppin 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles County Nursing Home LaPlata Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Feb. 14,1921 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖺 F 066-38-6012 87 Director **England** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20637 15080 Celar Brook Place USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Manied 2 ☐ Married Saltimore, Maryland 21215-0036 1 Yes XXNo þ Specify: Specify: 3€Vidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other than College (1-4or 5+) permit. Pages 1 and 2 should be filed v Depertment of Heelih and Mental Hygien Important: If Item 27 ie marked other th eny Injury or other treumatic event, Iffag **Production Assistant** Medical Products 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Collins O'Grady Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15080 Cedar Brook Place, Hughesville, MD 20637 Alicia P. Mrozowski/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/18/2008 Arlington National Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien end is the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as 1 igned by the attending be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cete hes been sig , page 2 should b 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes autopsy performed: 2□ No 1 Yes 2 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 5625 Allentown tatima Hus 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

JUN 1 T 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 08 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 1:15AM M CLYDE WILSON PACE JUNE 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 340 PERRY CABIN DRIVE ST. MICHAELS TALBOT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours **™** M 2□ F 90 Director 372-16-4108 NOV. 9,1917 MISSOURI Usual Residence of Decedent 10c. City, Town or Location 10d. Inside Cify Limits 10b. County 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD TALBOT MICHAELS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 340 PERRY CABIN DRIVE USA . Race · American Indian 21663 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or item any injury or other trainment. Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☐ No Specify ò Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 AIRPORT DEVELOPMENT TRANSPORTATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLYDE W. PACE ၉ MARY ROSE DIRCKX 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNNE PACE ROBINSON/DAUGHTER 624 S. ST. ASAPH ST., ALEXANDRIA, VA 22314 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 6/6/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. cardiovascular Immediate Cause (Final schote **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Esqueritially flet on differe, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last provediable flet over differ Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) 1 XYes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

P.O. Box 68760, Division or Vital Records. or Attending Physician; funeral After

Baltimore, Maryland 21215-0036

s after deam ral Director: Aft

16+ | VA

within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) 29c. License number 29b. Signature and title of certifie 00044282 RK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mp 4410 Bachelon Mt. Rd. CXFERD MD 21654

2008

5 Pending

investigation

6 Could not be determined

1 Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

31. Date filed (Month

State Registrar Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1		,	1 - For State Registrar	State of Mary	rland / Depa	artment of F	lealth and Death	Mental Hy	giene 0	18 20831
e.	Physici		1. Decedent's Name (First, Middle, La Ollie Mae Primes	,				2. Date of D Month		Year 3. Time of Death
	/Medio Examir			THE TIME	rm	4b. City, Town, o	NA PARK	ath (4c. County o	recovilly
To the second	Funeral Director		5. Social Security Number 6. S 577-64-6432 Usual Residence of Decedent	Sex 7. Age (In 1□M 203F 91	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		ay, Year) 1916 L	9. Birthplace (fiate or Foreign 11 Country) Nayes V111 ee Co, SC
	ith the Maryland or 28a-f show	Director	MD 10b. County Prince G	_	c. City, Town or Lo				10g. Citizen of Wi	10d. Inside City Limits ★2Yes 2 □ No hat Country?
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland It of Health and Mental Hygiene. If item 27 Is marked other then "natural", or Items 23a or 28s-f ehow or other treumatic event, Ite Medical Examinar must be neitlisd at	by Funeral	9018 51st Ave 11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced 15. Decedent's E (Specify only highest gr.	12. Was Decedent Ever Armed Forces? 1 Tyes 2\tilde{\textbf{N}}No If Yes, Give Year or Dates: ducation ade completed)	16a. Dece	20740 Was Decedent of Hif Yes, specify Cub. 1 ☐ Yes 25300 dent's Usual Occuping of work done	Specify:	erto Rican, etc.)	Black	- American Indian, , White, etc. Black
d 2121	filed within Hygiene. other then "	e Completed	Elementary/Secondary (0-12) 6 17. Father's Name (First, Middle, Last	College (1-4or 5+)	Homem	DO NOT use retire		lame (First, Middle	Private a, Maiden Sumame	·)
ırylan	2 should be and Mental Is marked o	To Be	Wilton Wells 19a. Informant's Name/Relationship (19b. Maili	ng Address (Street	Mary	Franklin		
Baltimore, Ma	Pages 1 and 2: nent of Health ar int: If item 27 Is iry or other treu	CSUSO	Delores House /Da 20a. Method of Disposition 1 \$\mathbb{Z}\$ Burial 2 \(\subseteq \text{Cremation} \) 3 \(\subseteq \text{Cremation} \) 4 \(\subseteq \text{Donation} \) 5 \(\subseteq \text{Other} \((Special columns) \)	Removal from State	20b. Place of Dispo	matory or other pla	сө)	Date	,	City or Town, State
Baltir	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice	-37	. 2	2. Name and Addre	ess of Facility			Vashington
8760,	be attending physicien and burnar-transit dor use as the burnar-transit	lical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. And caused the one cause on each line. Due to (or as a co	onsequence of):			SUSEMIE		Approximate Interval Between Onset and Death
O. Box 6	the death certifi y the attending ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date Mon	of delivery th Day Year
rds, P.	sign d be	Ď	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	inderlying cause giv	ven in Part I.			bute to the cause of death?
of Vital Records,	The law ate has b page 2 sl	Completed							opsy formed?	/ere autopsy findings available for to completion of cause of eath? ☐ Yes 2 ☐ No
on of Vita	To the Hospitel or Attending Physicien: I within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	ition: To Be	25. Was case referred to medical examiner? 1	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 DF Outpatier 28b. Time o Injury	of 28c. Injur	ner: 4 ☐ Nursing		one) sidence 6 Othe how injury occurre	
Division	el or Attendi s after death. sl Director: A sd in by the fu	Certification:	3 Suicide 6 Could not be determined			reet, factory, office			(Street and Numbe own, State)	r or Rural Route Number,
	the Hospitel hin 24 hours the Funerel npletely filled	edicai	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of m miner: On the basis of exa and manner stated	amination and/or in	th occurred at the till evestigation, in my o	me, date and pla opinion, death oc	ace, and due to the courred at the time	e cause(s) and man s, date and place, a	nner as stated. nd due to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	m M.) ·	29c. Licens			•	(Month, Day, Year)
	(2)	10	30 Name and oddress of person who all the state of the st	completed cause of death WYORKM 32. Registrar's	(Item 23a) (Type,	Print) 7600	Canal	1 he	Mean	0-2008 WA PARKE MD
	Sta Registi	_	JUN 1 3 2008	Boom &	grade.					

		7	State Registrar 1. Decedent's Name (First, Middle, La.		aryland / Depa <i>Cel</i>	rtificate	of I	Death		2. Date of De	Reg. No		20832
	Physici /Medi	cal	Juanita F. Poretz			4b. City, To		r Location	of Dooth	June June	- 1	2008 Year	4:30 PM
	Examir	ier	Casey House 5. Social Security Number 6. S		e (In yrs. last birthday)	Rockv	i11			8 Date of Rin	M	ontgomer	у
market from	Funeral Director		219-36-8397 Usual Residence of Decedent	M 2[XF 7. A9	87 Yrs.		Days	Hours	Min.	Oct 22	y, Year 1, 1	9. Birth 920 Vir g.	inia
A dominated the second	a-f show	ctor	10a. State 10b. County MD Montgome	ery	10c. City, Town or Lo	ocation		•					10d. Inside City Limits 1 ☐ Yes 2 No
d d	n with the	Funeral Director	10e. Street and Number 7625 Miller Fall	Road		10f. Zip (10g. Ci	itizen of What Cou	intry?
1215-0036	pormit. Pages 1 and 2 should be lifed within 72 hours after obeath with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	Was Decede If Yes, specif 1 ☐ Yes 2		lispanic Or an, Mexica <i>Sp</i> ec <i>ify:</i>		cify Yes or No Rican, etc.))-	14. Race - Ameri Black, White Specify: Wh	
21215-0036	nin /z nou e. an "natura Medical E	Be Completed by	15. Decedent's E. (Specify only highest gra	de completed) College (1-4or 5	(Give life.	dent's Usual kind of work DO NOT use	done d retired	during mos d)	st of workir	ng	16b. F	Kind of Business/li	ndustry
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Maryland	Mental Mental arked o	To Be	John L. Rhodes					Mary					
Mar	nd 2 sn alth and 27 is m r traum		19a. Informant's Name/Relationship (Patricia A. Ingal							od, MI		or Town, State, Zi 855	p Code)
Baltimore,	rages 1 a nent of Hea ant: If Item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		20b. Place of Dispo cemetery, cre. Chesapeal					ate 3/08		ocation - City or T	
Balt	Depart Depart Import arry in		21. Signature of Funeral Service Lice	toutte	MO1251 Be	verly	L.	Heck	rotte	P.A.	C1	P.O. Box arksvill	x 784 e, MD 21029 Approximate
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13 "	- Q 10	Completed by								24a. Was auto perfe 1 Yes		prior to c death?	topsy findings available ompletion of cause of
Division or Vital	the Hospital of Attending Physician: The law hin 24 hours after death the Euneral Director. After this certificate has mpletely filled in by the funeral director, page 2 and the funeral director, page 2 and filled in by the funeral director.	Certification: To Be (25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not b	0	ıry 28b. Time o lnjury	of 28	c. Injur Wor 1 🔲	er: 4 □ N	ursing Hor	28d. Describe	idence how inj	ury occurred	hospice
Divi	the Hospital of At thin 24 hours after of the Funeral Direc mpletely filled in by	Medical Certifi	4 ☐ Homicide determined 29a. Certifier	building, et	ury - At home, farm, st. c. (Specify) of my knowledge, deal y examination and/or in	th occurred a	t the tii	me, date a	ind place, a	City or To	wn, Sta	s) and manner as	stated.

(1S) AZ

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855 32. Resistrar's Signature JUN 1 3 2008

State

Registrar

D64615

June 12, 2008

Yes, Give Yeer

Baltimore, MD 21215-0036 Department o Important: I Physicia /Medica xamine

Widowed

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

af 1, 19	ρ	3 Widowed 4 Divorce	ced If Yes, Give Yeer or Dates:	1 Yes 2 X	No specify:	Specify: WI	1 LE
ours a	9	15. Decedent's Education (Specify			pation (Give kind of work done	16b. Kind of Business/In	dustry
72 h	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working i	ife. DO NOT use retired)		
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ed wi	Ö	17. Father's Name (First, Middle, La	ast)	·	18.Mother's Name (First, Middle, M	Maiden Surname)	
be file ntal H 'ked e ent, ti	Be	EDWARD CHARLES	ROSEMARY		VERONICA ANN M	MORRIS	
Mei Mei mai	ဂ္	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (St	reet and Number or Rural Route Num	nber, City or Town, State,	Zip Code)
permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		EDWARD CHARLES	ROSEMARY/FATHER	20741 EWING	G ROAD, PRESTON,		
l and Heal Fiten		20a. Method of Disposition		Place of Disposition (Name of crematory or other place)	cemetery, Date	20c. Location - City or 1	Town, State
ages ent of nt: I		1 XBurial 2 Cremation 4 Donation 5 Other Spec	3 Nemoval Irom State	FORD CEMETERY	6/13/2008	OXFORD, M	ARYLAND
artme sorta		21. Signature of Funeral Service Lie	my.				HOME DA
Tinji Tinji		JOHN Z. M	ERCERON	FELLOWS,	ess of Facility HELFENBEIN & NEVARRISON ST., EAS	TON. MD 2160	HOME PA
nysician		23a. Part I. Enter the disease, or co	implications that caused the death	. Do not enter the mode of dying	ng, such as cardiac or respiratory arr	est, shock, or heart	Approximate Interval
Medical		failure. List only one cause on	each line. a. Torso Injuries				Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of	nf):			
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icate phy the b	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		o Destroit conservation	23d. Date of delivery	ay Year
certif nding se as	ä	past 12 months?	1 Live birth 4 Pregnant at time of de	noth	3 Ectopic pregnancy	Month D	ay Year
leath e atte for u	Physician/Medical	1 Yes 2 No 9 Unkno		5 Other (Specify)		7	
the d by the	F.	Part II. Other significant condition	The second second	resulting in the underlying cause	se given in Part I. 23e. Did to	obacco use contribute to	he cause of death?
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	by				1 Yes	s 2 No 3 Prob	ably 4 Unknown
quire sen sig uld b	Completed				24a. Was	an 24b. Were au	topsy findings available
aw re nas be 2 sho	ble				autor	osy prior to c ormed? death?	ompletion of cause of
The l cate l page	6				1 ✓ Yes		s 2 No
ian: ertifi ctor,	Be	25. Was case referred to medical examiner?		26.PI	ace of Death (Check only one)		
hysic this c	2	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other Nursing Home 5	Residence 6 🗸 Other	: Scene
ing P After unerz	Ë	27. Manner of Death	28a. Date of Injury (Month, Day,Year) Jun 7, 2008	0045	- Occupant a	how injury occurred uto fixed object col	lision
eath. Ior: the f	ig	1 Natural 5 Pendin 2 ✓ Accident Investig	g '	0215 hrs 1	Yes 2 ✔ No		
or At fter d Sirect in by	ij	3 Suicide 6 Could	28e Place of Injury - At h	nome, farm, street, factory, offic	ce building, etc. 28f. Location (or Town, 5	Street and Number or Ru	ral Route Number, City
urs al	Certification:	4 Homicide determ		et	Frazier Neck	Rd. West of Skeleton	Creek , Preston, MD
Hosp 24 ho Fune tely f	calc	29a. Certifier 1 Certifying Phy	sician: To the best of my knowled	ige, death occurred at the time	e, date and place, and due to the cau	se(s) and manner as state	ed.
thin the mple	dic	one) 2 Medical Exami	iner:On the basis of examination a and manner stated.	and/or investigation, in my opin	nion, death occurred at the time, date	and place, and due to the	e cause(s)
F 3 F 3	Medi	29b. Signature and title of certifier	Circ marinor states.	29c. Lic	ense number	29d. Date signed (Mor	nth, Day, Year)
		Mill. Burn	. Ol M	0.	C.M.E.	June 7, 2008	
		30. Name and address of person w		n 23a)		1	
+VA		Melissa Brassell, MD	Assistant Medical Exami		, Baltimore, MD 21201		
	ote	31. Date filed (Month, Day Year)	3 Registrar's Signat	ure			
Regis	tate	JUN 1 1 2	008	Mark .			

ORIGINAL

Yes 2 X No specify:

WHITE

Specify:

Reg

5+VA

			1 - For State Registrar	State of	Marylar	id / Depa <i>Cei</i>	artment of F tificate of a	lealth and l <i>Death</i>	Mental Hy	/giene Reg. No.	2008	20834
	Physici	an	Decedent's Name (First, Min					**	2. Date of D Month	eath Day	Year	3. Time of Death
	/Medio		Joanne 4a. Facility Name (If not institu		nhar)		4h Cihi Touri	r Location of Death	June	- 5	2008 County of Death	3002
	Examir	ıer	Good Samarit				Balt	imore	l.	- 1	Baltimo	re
9.	Funeral		5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of B			
X	Director		579-90-8472 Usual Residence of Decedent	1□M 2ᡚF	4	3 Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D Aug. 28	, 1964	Was	place (State or Foreign h.D.C.
	yland low		10a. State 10b. Cou	nty	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	death with the Maryland ms 23s or 28e-f show I must be notified at	ţō	Md. Anne	e Arundel		Gle:	narden					ty∐Yes 2 ☐ No
	th the	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	th wi		7935 Johnso	on Ave.			207	706		υ	J.S.A.	
	r dea	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U	.S. 13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or N	0- 1	4. Race - Ameri Black, White,	
036	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itema 23a or 28e-f show or other traumatic event, Ite Medical Examinat must be notified at		1⊠ Never Married 2 Never Married 2 Never Mar	If Yes Giv	9	1	☐ Yes 2 No		,		Specify: B1a	
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09770 nd 21215	within ine. than "	Completed by	Elementary/Secondary (0-12		-4or 5+)	life. L	OO NOT use retired None	during most of word)	9		N/A	
90	filed v Hygie other t	ပိ	17. Father's Name (First, Midd	le, Last)		<u> </u>	None	18. Mother's Nam	e (First, Middle	a. Maiden S		
JC	ld be ental ked c	To Be	John Roger					Shir1		ston		
a y	should and Men s marke umatic	-	19a. Informant's Name/Relation			19b. Mailin	g Address (Street	and Number or Ru	ral Route Numb	per, City or	Town, State, Zij	Code)
Na.	and 2 ealth a n 27 is		John Roger	s (Brother)		6945	Emerson :	St. Hyatt	sville	, Md.	20784	
Rogers Joanne Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema any injury or other traumatic event, the Medical Examinating once.		20a. Method of Disposition 1 □ Burial 2 ☑ Crematic 4 □ Donation 5 □ Other	n 3 Removal from S	State	emetery, cren	sition (Name of natory or other place Cremator	ce)	Date 4 2008		ation - City or To erdale,	
Baltin	permit. F Departm Importar any injus		21. Signature of Funeral Servi		Office	22 C	Name and Address	ss of Facility Funeral H	lome & (Cremat	torium,	P.A.
	40240		23a Part1 Enter the disease	or complications that ca	used the deat	5	801 Clev	eland Ave	. Rive	dale,	, Md. 20	0737 Approximate
	Dharatalaa		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final	4 14							1	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	O Scher		Carolio	suscelow	()2 ile	10		unkown
	Examiner		Savurantially list conditions	b	,							
	pe psit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (d	or as a conseq	uence of):						
	al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):						
68760,	ificate be executed g physicien and as the burial-transit	edical		d								
	ertific ding p		IF FEMALE:	22 . 14								
Bo	attending for use a	lan	23b. Was decedent pregnant in the past 12 months?		come of pregna rth 2 ∏ Feta ant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	′		23	3d. Date of delive Month	ery Day Year
o.	by the destached	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkno		J_	Ottlet (specify)					
s,	res tha igned be del	þ	Part II. Other significant cond	1					1			he cause of death?
oro	w requir been si should	eted	- syste	mie lup	W C	ryym	ena for	J	1.0	Yes 2		pably 4 Onknown
Division of Vital Records, P.O. Box	Attanding Physiclen: The law requires that the death cer rideath. sctor: Atter this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use	Completed							24a. Was auto perfi		prior to co death?	ppsy findings available impletion of cause of
Ta	iclen: Th certificete rector, pag	BeC	25. Was case referred to medi examiner?	cal	-			26. Place of Dea			10163	20110
>	Physic this ce al dire	ē	1 ☐ Yes 2 ☐ No	Hospital: 1 □ Ir	patient 2 🗷	ER/Outpatient	3□ DOA Othe	er: 4 Nursing H	ome 5 Res	idence 6	Other (Specia	5 y)
0 0	ding Ph h. After th funeral	iuo	27. Manner of Death 1 ☑ Natural 5 ☑ Pen	28a. Date o (Month	f Injury o, Day Year)	28b. Time of Injury	28c. Injury Work	y at k?	28d. Describe			
isic	Attendi death. ctor: A y the fu	lcat	2 ☐ Accident inve	stigation	of latina A h			Yes 2 □ No	206 1	(Ch		/B
Div	tal or A	Certification:		mined 286. Place buildin	of injury - At no g, etc. (Specif)	ome, farm, stre	et, factory, office		City or To	Street and wn, State)	Number of Rur	al Route Number,
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	edical	29a. Certifier 1 Certification (Check only one) 1 Medic	ying Physician: To the al Examiner: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) a date and p	nd manner as s blace, and due to	tated. o the cause(s)
	To th withir To th comp	×	29b. Signature and title of certi	fier 10 -			29c. License				signed (Month,	
			> Surenot	14/2).	38543		Jun	e 5,2	300
60	(1)		1200111 0	no o mpleted cause	of death (Item	23a) (Type, F	Print)	7 /	0 7	2 (1		2/239 Vary Jund
W.			31. Date filed (Month, Day, Yei	cruggs Mi) 5000	ling of a	h Rave	Pouleva	nd P.	e-lti	norp 1	day lund
	Sta Registra	_	JUN 1 3 200	Boom)	gistrar's Signa							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State Registrar/Amend#1.PerPhys.PCC6-13-08cr Certificate of Death Reg. No. 2 1 1 8 Rios 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12:12 PM Physician 2008 10 06 UWE Trunca /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Samaritan Hospital Good 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Virginia 1 ☐ M 2 💢 F 226-12-1919 01-11-1948 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No r 28a-f sh notified Director MD10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o e Linworth "natural", or items 23a dical Examiner must t Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Therapy Hide

18. Mother's Name (First, Middle, Maiden Surname) the 244 and 17. Father's Name (First, Middle, Last) 2 should be f and Mental I Gertrude ward owe Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, HD &12
Date | 20c. Location - City or Town, State HOD 21239 12105 Linworth Gue. Department of Health Important: If Item 27 Migdalia 1253 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-17-08 Warsaw, UA. Northern Neck Crematory injury 21. Signature of Funeral Service License Pridger Funeral Service 9908 Sassafras lane Mutchellwille, was 20721 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks Due to (or as a consequence of): **Physician** /Medical Examiner Multiple Myclom years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed -tran and Due to (or as a consequence of): physician a sthe burial Box 68760, Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 🗌 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? /es 2**V**INo page 2 No 1∐ Yes 1 ☐ Yes certificate Vital rector, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2₩ No 2 ER/Outpatient 3 DOA Inpatient ၉ Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 06-10-2008 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR KAZORY Blvd, BaltimoreMD21239 Loch Raven

State

Miranda

Ross

31. Date filed (Month, Day, Year)
JUN 1 3 2008

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month 10, 5:19am Darrel1 Wallace Reeder June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F 577-74-3468 April 5, 1953 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Prince Georges Forestville 1 X Yes 2 No 10f. Zip Code 20747 10g. Citizen of What Country? # 202 6413 Hil-Mar Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Wallace Constance Wood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley E. Reeder - Wife 6413 Hil-Mar Drive # 202 Forestville MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem. Cemetery 6/17/2008 Landover Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Pope Funeral Home 21. Signature of Funeral Service Lice 5538 Marlboro Pike Forestville Md 20747 HOIOSS Inter the disease of complications, at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the results of the complex of the comple Approximate Interval Between Onset and Death Immediate Cause (Final Sephicemia Due to (or as consequence of): disease or condition resulting in death) Injected Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last torta Due to (or vs a consequence of) Melastatic aranomo Due to (or as a consequence of). 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 DEctopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown

Physician /Medical Examiner

that the death certificate be executed

signed by the a

funeral director,

filled in by

After t

al or Attending Patter death.
I Director: After de in by the funera

To the Hospital within 24 hours al

Division or Vital Records, P.O. Box 68760.

Physician

/Medical

Director

Funeral

۵

Completed

10a. State

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

purnit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mentai Hygiene. In profrant: If them 27 is marked other than "natural", or items 23a or 2, any injury or other traumatic event, the Medical Examinar and once.

Baltimore, Maryland 21215-0036

Examiner attending physician and for use as the burial-transit

Physician/Medical ģ

Completed

Certification: To

Medical

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

24a. Was an autopsy performed 1 Yes 2 No

26. Place of Death (Check only one)

HMON

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼ No 2 💢 No

25. Was case referred to medical 1 Yes 2 No

27. Manner of Death 2 Accident 3 Suicide

4 ☐ Homicide

5 Pending investigation 6 Could not be determined

1 Inpatient Date of Injury (Month, Day Year)

2 ER/Outpatient 3□ DOA 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

ROAD

Pertifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Vilceman

MD

06318

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY SHRI KAMMAN

31. Date filed (Month, Day, Year) JUN 1 3 2008

7503 32. Registrar's Signat

Registrar

DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2008 Month **Physician** June 10, 3:10 Louise Irene Rej /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Rocky Ridge 10674 Rocky Ridge Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 25, 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number, 7. Age (In vrs. last birthday **Funeral** Days Months 1 ☐ M 2 🔀 F Hours 1921 062-18-3344 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f shov ther traumatic event, the "Modical Eventine", ust by notified at 1 ☐ Yes 2 No Director MD Frederick Rocky Ridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 21778 USA 10674 Rocky Ridge Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Drabik Mary Swiatek ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 10674 Rocky Ridge Road Rocky Ridge, MD 21778 Paul Rej/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory | 06/12/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 MO1251 Beyerly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Advanced Nonsmall Cell Lung Cancer 18 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner be executed Due to (or as a consequence of): burial attending physician for use as the burlal Box 68760, Physician/Medical certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ▼ No Month Day Year 5 Other (specify) P.O. the 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an has autopsy certificate 1 ☐Yes 2 ☐XNo director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ****No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi ne Hospital or Attending Pl n 24 hours after death. he Funeral Director; After t bletely filled in by the funera 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D41866 June 11, 2008

State Registrar

DHMH 17 Rev 1/2001

#200 Frederick, MD 21702

Thomas Johnson Dr. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kanan Hudhud M.D. 46B

JUN 1 3 2008

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2008 20838 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jun 20, 2008 8:20am [™] Stevenson Dorothy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick St. Catherine's Nursing Center Emmitsburg | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day Year | May 13, 1911 Birthplace (State or Foreign Country)
 A 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ € 97 Director 215-68-6567 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show of Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23e or 28e-1 show other traumatic event, it a Medical Examinar must be coulded at MD Allegany Cumberland 1 □Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 604 Montgomery Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0036 If Yes, Give Year or Dates: Specify: white 3 □XVidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 1:2 College (1-4or 5+) beautician beauty salon 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leot Brown Blacka Henry Blacka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar important: if Item 27 is any injury or other trau PΑ 17320 5 Maple Trail Carolyn Simpson daughter Fairfield Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 □ Kirial 2 □ Cremation 3 □ Removal from State 6/23/2008 Hillcrest Memorial Park MD Cumberland 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Eacility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, shock, or heart failure. L complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician NEWWON A /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending | 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificete has been signed rector, page 2 should be de 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an TRUSCON CHLONIC DEMEDITA 1 Yes 2 No : After this certifice funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Directompletely filled in by 4 - Homicide To the Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JUNE 20, 2008 FAIRFIELD RD., SUITE A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HISDREW M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 6 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 008

Certificate of Death 20839 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month June 21, 2008 **Physician** Melvin Samuel Sloan 10:45 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lonaconing Allegany Egle Nursing and Rehab Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) January 02, 1917 **Funeral** Days Hours Months 1 M 2□ F Maryland 217-10-4832 Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 □ No Lonaconing Director Allegany Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21539 15803 Lower Georges Creek Road Funerai 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after nand Mental Hygiene.
Is marked other than "natural", or Itel 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify. à 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 0 Laborer Textile 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Donald ပ Samuel Sloan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Heelth an ant: If item 27 is: ury or other trau Audrey Sloan - Wife 15803 Lower Georges Creek Road, Lonaconing, Maryland 21539 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 22, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) **Cumberland Crematory** Cumberland, Maryland 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. Nicken for E. 8 East Main Street Lonaconing, MD 21539 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovasculer accident Lochemic Physician disease or condition resulting in death) /Medical Cerebro Vasculer disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of) Examine been signed by the attending physicien and should be detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ allero sclero tic 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 TYes d or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours aff To the Funeral Di 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier evin mo 021488 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4+1 Devlin M.D. 20 Douglas Avanue, Lanaconing, Maryland 21539 Thomas 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 6 2008 Registrar

		For State Registrar		State of	Marylar	nd / Depa	artmen rtificat	t of H	ealth a Death	and M	lental Hy	/giene <mark>2</mark> (800	20840
Physicia /Medic		Decedent's Name (First, Mid HARRY THU		SMTTH							2. Date of D Month JUNE	Day	Year 008	3. Time of Death 1:30AM M
Examine		4a. Facility Name (If not instituted)	ion, give s	street and num	ber)		1		Location of			4c. Cour	nty of Death	
Funeral Director		5. Social Security Number 215–38–0919	6. Sex	M 2□F	7. Age (In yrs. 65	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D NOV 1	irth Pay, Year) 3,1942		place (State or Foreign ntry) YI.AND
le Maryland 8a-f show btifled at	ctor		•	STER	10c. Ci	ty, Town or Lo		ARKE	r .					10d. Inside City Limits 1X Yes 2 □ No
3a or 2	Dir	10e. Street and Number 5917 HERITAG	E ROA	a D			10f. Zip		21631			10g. Citizen d	of What Cou SA	intry?
Jac	ed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ M 3 □ Widowed 4 □ Divorce	arried ed	12. Was Dece Armed For 1 X Yes If Yes, Give Year or Da	ces? 2 [No		Was Dece If Yes, spe 1 ☐ Yes dent's Usu	dent of Hi cify Cuba 2 X No	spanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)	В	lack, White	re.
within 72 tene. than "nat	Completed	15. Deced (Specify only hig Elementary/Secondary (0-12	hest grad	College (1-	4or 5+)	1 (Give	kind of wo DO NOT u	rk done c	lurina mos	t of work	ing	160. Kind of	business/ii	igustry
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Maryland 2. All 2 should be filed with and Mental Hygie 77 Is marked other to traumatic event, the	To Be	EMORY SMITH							G	RACE	LEWIS			
Baltimore, Mar permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum		19a. Informant's Name/Relation BONNIE SMITH 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other 21. Signature of Funeral Servi	/WIFE n 3□P (Specify)	emoval from S	cH.	5917. Place of Dispondentery, cree ESAPEAI	7 HER position (Name matory or o KE CR 2 Name au	ITAG	E ROA ON C S of Facility HELFE	D, E	AST NE Date /9/200 N & NE	ber, City or Tov W MARKE 20c. Locatio STEVE WNAM FU TON, MD	T, MD n - City or T NSVIL NERAL	21631 own, State LE, MD HOME PA
Physician /Medical Examiner the prival-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (o	or a a need	quence of):	true	tive	pul	man	J di	SUSS		Onset and Death 3 years
ath certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2		rth 2 ☐ Feta ant at time of o	al death 3	⊒Ectopic p ⊒ Other <i>(sp</i>						Date of deli	very Day Year
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VItal rsician: T s certificate firector, pa	To Be	25. Was case referred to med examiner? 1 ☐ Yes 2 → No	_	lospital:	patient 2□] ER/Outpatie	nt 3 □ D0	Othe	or:		h (Check only	one) sidence 6 🔠	Othor (Snoo	in Wate 1
dlng P	Certification: T	3 Suicide 6 Cou	ding stigation ld not be ermined	28a. Date of (Month)	f Injury n, Day Year) of injury - At h	28b. Time of Injury	f M	28c. Injun Work 1 □			28d. Describe	s how injury occ	curred	ral Route Number,
ital or urs afte ral Din		29a. Certifier 1-Certif	ying Phy	sician: To the	best of my kno	owledge, deat	h occurred	at the tin	ne, date ar	nd place,	and due to th	e cause(s) and	manner as	stated. to the cause(s)
To the He within 24 To the Fe complete	Medical	29b. Signature and title of pert	-	and mann	er stated.	and/or Ir		c. License		au occul	ieu at tiie time	29d. Date sig		
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State of Maryland / Department of Health and Mental Hygiene 20841 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2008 8 JUNE 11:20 AM EZEKIEL SPEIGHT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 16 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 58 Hours Months Days Min 1 XM 2 ☐ F Yrs. NORTH CAROLINA 1949 Director 227-70-3388 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 √Yes 2 No Director PRINCE_GEORGE'S FT. WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20744 7401 JAFFREY ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exeminer and Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 2 YRS OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be TAYLOR MARY RAYMOND SPEIGHT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7401 JAFFREY ROAD FT. WASHINGTON, MARYLAND 20744 CHERYL A. SPEIGHT/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MARYLAND RESURRECTION CEMETERY 6/17/2008 J. B.JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** iram positive COCCI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No tension 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 70 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Rd #205 Ft. Washington, MD 20744 31. Date filed (Month, Day, Year) State JUN 1 3 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 20842 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 Ingrid A. Soper June 12, 8:08 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collington Nursing Home Mitchellville Prince George's Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗓 F Director 057-05-5157 1913 Jersey City, NJ 94 Aug 4, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar must be notified at Director 1 Yes 2 No Maryland Prince George's Mitchellville the 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 10450 Lottsford Road 20721 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ANo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify White Completed by Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Johnson P Agnes Moen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doug F. Soper - Son 1617 Portland Lane, Bowie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory 6/13/08 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician Chronic obstructive pulmonary disease Years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of law requires that the death certificate be executed Exam attending physician and for use as the burlal-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 □Yes 2X No 2 🗌 No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at 28d. Describe how injury occurred 1 X Natura Injury 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 24 hours a 29a, Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the P within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MA D25079 6/12/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Don Yablonowitz 7404 Executive Pl., Ste 502, Lanham, MD 31. Date filed (Month, Day, Year) 32. Registrar's Sign State JUN 1 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6/11/2008 RUTH 7:20 A M ETHEL 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4511 Pine Valley Ct. Middletown Frederick If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🔀 F 6/21/1926 MD 81 218-22-6302 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Frederick Middletown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4511 Pine Valley Ct. 21769 USA . Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐ Yes 2**X** No Specify. Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Her Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Henry Cheelsman Eva Marie Gerhard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4511 Pine Valley Ct., Middletown, MD 21769 Ruth Tousignaut/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6/16/08 ¶ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Denation 5 ☐ Other (Specify) Crownsville Veterans Cemetery Crownsville, MD 21. Signature of Funeral Service Ligensee Burrier-Queen Funeral Home & Crematory, P.A.

Physician /Medical **Examiner**

permit. Page Department o Important: If a

Physician

/Medical

Examiner

10a. State

Director

Funeral

Completed by

Be

P

MD

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnent of Heath and Mental Hygiene. and the first 27 is marked other than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than "natural", or items 25a or 28a-f show ant; If item 27 is naturalic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

requires that the death certificate be executed

Examine

Physician/Medical

burial-trar be a page 2

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Pl within 24 hours after death. • To the Funeral Director: After the completely filled in by the funeral MJL

1	Jeenny 1) () () () () () () () () () (MD 21784
	23a. Part1. Enter the disease, or o shock, ir heart failure. List of	complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line.	Approximate Interval Between Onset and Death
	Immediate Cause (Final dise se or candition resulting and eath)	PNEU MONIA	3 weeks
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Chronic Obstructive pulmonary disease to (or as a consequence of):	e 2+ year
	that initiated events resulting in death) Last	c Due to (or as a consequence of):	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1	delivery Day Year
	Part II. Other significant conditio	ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribut	e to the cause of death?

od be	Atrial	fibrillatio	2		1 ☐ Yes 2[□ No 3 Probably 4 □Unknown
complete					24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
٥	25. Was case referred to medical			26. Place of De	eath (Check only one)	
0	examiner? 1 Yes 2 Ho	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	3 ☐Other (Specify)
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
enince	3 Suicide 6 Could not be determined		ome, farm, street, fact	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
dical		Physician: To the best of my kno aminer: On the basis of examina and manner stated.				
×	29h Signature and title of certifier	0	2	29c. License number	29d. Dat	e signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lames L. Koessler MD 90 BOX 20 D20488 6-11-08 Middletown, MD, 21769

State Registrar

JUN 12

31. Date filed (Month, Day, Year)

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:47 PM June 22, 2008 ROBERT JOSEPH THOMAS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 □ F 68 Feb. 16, 1940 Illinois Director 354-30-2311 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-4 or any linjuy or other traumatic event, the Medical France. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h. County 1 ☐ Yes 2 No Maryland Frederick Myersville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4239 Crow Rock Road 21773 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Specify. White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 **Epidemiologist** Health and Safety 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward C. Thomas Josephine Jean Kasmauskas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Darlene Wolfe-Thomas/wife 4239 Crow Rock Road, Myersville, Maryland 21773 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory June 26,2008 Smithsburg, Maryland 20a. Method of Disposition 1 ☐ Burial 2 Tremation 3 ☐ Removal from State 4 □ Donation Other (Specify) Funeral Service Lidensee 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, defeat failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final COVOURN **Physician** probable acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, boung to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No page, the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar

6

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Myung Hee Nam, M.D.,

<u>JUN 2 6</u>

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

To the

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

MDD 35106

400 West Seventh Street, Frederick, Maryland 21701

29d. Date signed (Month. Day. Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:19am June 4, 2008 Mignonette Audrey Tinsley /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 192 Fleetwood Terrace Silver Spring 8. Date of Birth (Month, Day, Year) 12/19/1935 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X F Director 72 Washington, D.C. 579-56-1140 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Y Yes 2 No Director Silver Spring Marvland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 192 Fleetwood Terrace 20910 United States Funeral . Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Black ģ 3 ☐ Widowed 4 X Divorced Be Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Postal Account Rep. U. S. Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Oceola Thornton Flora Stevenson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 192 Fleetwood Terr. Silver Spring Md. 20910 Robert Tinsley / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 6/12/2008 Washington, D.C. Olivet Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PANCREATIC CANCER 0 Months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown cate nas been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ★★No 24a. Was an autopsy performed? 2 No To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2X No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D54378 June 10, 2008 30. Name and address of person who completed o use of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Cheryl Aylesworth MD 31. Date filed (Month, Day, Year)

JUN 1 2 2008

2730 University Blvd. Suite 400 Wheaton, Maryland

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:
Completely filled in by the To the Hospitai

0 State

Registrar DHMH 17 Rev 1/2001

Medical

29a. Certifier

NURUL CHOWDHURY, MD: 15216 DINO DRIVE; BUR TONSVILLE, MD20866 31 Date filed (Month) Day, Year) JUN 1 2 2008

29b. Signature and title of certifier

Chowdly, mi)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 6/5/08

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 10:45p ^M Helen Tschiffely June 11 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Thurmont Frederick 13 East Moser Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 👿 F Maryland Director 220-16-1400 May 8, 86 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Evanciant must be notified at once. Director 1X Yes 2 □ No Frederick Thurmont Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21788 13 East Moser Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 □Yes 2 X No Specify ≥ 3 ☑ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Rudy ျ James Ross Eyler, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas A. Tschiffely / Son Hyattsville, Maryland 20783 7500 Adelphi Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 19 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State June 2008 Emmitsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Anthony's Cem. 21. Signature of Funeral 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 104 E. Main Street thurmont, Maryland 21788 23a. Part1. Enter the diseast or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 Months Colon Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia, Coronary Artery Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 K No 2 🛛 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D Medical 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tle of certifier June 13, 2008 D26516 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1475 Taney Avenue # 204, Frederick, Maryland 21702 Gilson M. Allen D. 31. Date filed (Month, Day, Year) gistrar's Signature State 2008 JUN 13 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ellen Tedder 2008 8:40 a M 10, /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4607 Coachway Drive Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days 1 M 2 XF Yrs. Director 577-01-9694 90 May 16, 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sh Director 1 ☐Yes 2 ☐XNo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4607 Coachway Drive 20852 USA Completed by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filled within 72 hours after or nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iten Iry or other traumatic event, the Avidical Examiner Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathaniel Clarence Guy Margaret Rose Mattingly မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Spain Tedder, Jr./Husbahd 4607 Coachway Drive, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ₽ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. June Gate of Heaven Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home 500 University Blvd, W., Silver Home Inc. Spring, MD 20901 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronary Artery Disease 20 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension 20 years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a conse uence of Examir requires that the death certificate be executed sician and burial-trans Hyperlipidemia 20 years Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ Alzheimer's Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 1 ☐Yes 2 ☐No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 📉 Natural 5 ☐ Pending investigation neral Director: A filled in by the fi death 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of gertific 29c. License number 29d. Date signed (Month, Day, Year) d16495 June 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10401 Old Georgetown Road, #104, Bethesda, MD 20814 Joel L. Goozh, MD Registrar's Signature 31. Date filed (Month, Day, Year) State 1 2 2008 JUN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** <u>10:20 Рм</u> 2008 June Thelma Anna Thompson /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Clinton Prince Georges Bradford Oaks Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛚 F Hours Months Days 215-34-3260 Director Sept. 1935 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show notified at 1 ☐ Yes 2 No Director <u>Maryland|Charles</u> <u>Indian Head</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 26 Highland Place 20640 within 72 hours after death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Y Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other transmatic. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Norman Thompson ၉ <u>MaryElsie Thompson Thompson</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2905 Edgewood Road, Bryans Road, Maryland, 20616 ce of Disposition (Name of Date 20c. Location - City or Town, State <u>Francis Thompson/ Brother</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Charles Cemetery 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 □ Cremation 3 □ Removal from State June 13, 2008 Indian Head, MD. 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service L 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? ρ Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I ned by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. signt I be c 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s has autopsy perform death? certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 42 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert

State Registrar Name and address of

31. Date filed (Month, Day, Ye

Ulving. 170h

person who completed cause of death (Item 23a) (Type, Print)

2008

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 Physician 2 JUNE 11:55 AM WHITAKER WILLIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Days Months 1 XM 2 □ 1951 NORTH CAROLINA JAN 1 57 **Director** 578-70-1608 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director PRINCE GEORGE'S RIVERDALE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20737 6501 BALTIMORE AVENUE Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 █****No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married BLACK 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than PRIVATE SUPERVISOR 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill h and Mental H Be ALICE WHITAKER UNKNOWN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any Injury or other traun 5410 QUESADA ROAD RIVERDALE, MARYLAND 20737 CLAUDIA PROCTOR/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 6/14/2008 RIVERDALE, MARYLAND RIVERDALE CREMATORY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to was a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar ue to (or as a consequence of) Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 I Inknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ₩ No 24a. Was an perform certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 🔲 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 atural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 rtifuing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2. To the I and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 5000,2108 cause of death (Item 23a) (Type, Print) £3-350 FIW MD 20744 31. Date filed (Month, Jay, State 3 2008 JUN 1 Registrat

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6-9-2008 **Physician** 00:26 AM WYNN VICTOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE 5. Social Security Number 6. Sex if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 4-2-1958 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ₩ M 2 □ F WASH., Director 579-84-0112 50 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 XYes 2 No Director MD PRINCE GEORGE TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with 2503 SOUTHERN AVENUE # A2 20748 U.S.A. Funeral items ? 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or item edical Examiner r Armed Forces?
1 ☐ Yes 2 No 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: BLACK 3 ☐ Widowed 4 🎇 Divorced Completed Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) YEAR Elementary/Secondary (0-12) MAINTENANCE WORKER F.B.I. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY J. GEIBEL RODGER E. WYNN, SR. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSE WYNN-WHEELER - SISTER 4709 COLBY DRIVE KILLEEN, TX 76542 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEMETERY 6-18-2008 BRENTWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PINCKNEY - SPANGLER F. H. WASH., DC 20002-5236 524 - 8TH ST., N. E. 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Con Know disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner death certificate be executed burial-tra resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, nding physician Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign 1 Yes 2 No 3 Probably 4 Donknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 HNaturai 5 Pending investigation ours after death.

leral Director: Af
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 heringstones 843-350 32. Registrar's Signa 31. Date filed (Month, Day, Year) State JUN 1 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** a^M Gladys Steinberg Weber June 06 2008 7:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Carroll Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 X F Director 218-24-1396 Apr 18 1929 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at Carroll MD Westminster 1 ☐Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 522 Old Baltimore Road 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: White Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 C&P Telephone Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Steinberg Barbara Kolhes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: if item 27 is any injury or other trau 306 High Street New Windsor, MD21776 Barbara Blacksten/daughter P.O. Box 163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 06/1072008 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial Gardens Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. fail ? 21157 412 Washington Road Westminster, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** breat CARCINGAN Melashanc 3 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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MJZ

State Registrar 31. Date filed (Month, Day, Year) 32. Reg

STONER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue CSTMVSTER

32. Registrar's Signature

listrar's Signature

THOMAS

			For State Registrar	State of Marylan		tificate of i		, ,		00051
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*	Physicia /Medic	-	MABEL EVA	WOI	RKMAN			6/11/		19:25 P M
	Examin	er	4a. Facility Name (If not institution, give	ŕ			Location of Death		4c. County of D	eath
-		Ä	CHESTER RIVER MAN 5. Social Security Number 6. Sep		last hirthday)	CHESTE If Under 1 Year		8. Date of Birth	KENT	Birthplace (State or Foreign
,	Funeral Director	ŭ.		M 2√□ F 97	Yrs.	Months Days	Hours Min.	(Month, Day 7/18/1	r, Year)	Country) DE
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	e Mar 3a-f sl tified	ctor	MD KENT	KE	NNEDYV	ILLE				1 ☐ Yes 2 🔀 No
	vith th	Dire	10e. Street and Number			10f. Zip Code	_		10g. Citizen of What	Country?
	eath v	eral	29132 RICKS LANDI	NG RD. 12. Was Decedent Ever in U	S 13 V	21645		ecify Yes or No-	USA 14. Bace - A	merican Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If term 27 is marked other than "natural" or items 23a or 28a-f show important: If term 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		fYes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		/hite, etc.
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d 2	filed Hygie	ပ္သ	17. Father's Name (First, Middle, Last)	UNK	LIC.	I RAC. NO		e (First, Middle,	Maiden Surname)	
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ary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Ty	oe. Print)	19b. Mailin	g Address (Street	and Number or Rui	al Route Numbe	er, City or Town, Stat	te, Zip Code)
Σ,	1 and 2 Health em 27 i		JAMES O'HARRAH/SON						EDYVILLE,	
Baltimore,	Pages 1 nent of H nnt: If iter ury or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F	emoval from State	Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Location - City	or Town, State
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Ö,	ficate be executed physician and sthe burial-transit		resulting in death) Last	Due to (or as a consec	ruence of):					
68760,	ate b	edical		l						
P.O. Box 6	The law requires that the death certific te has been signed by the attending r age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	aldeath 3□	Ectopic pregnancy	1		23d. Date of Month	delivery Day Year
	that i	/ Ph	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribut	te to the cause of death?
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7	Physic this c	၉	1 ☐ Yes 2 ☐ No	fospital: 1 ☐ Inpatient 2 ☐			4 Hoursing Ho		lence 6 Other (S	Specify)
nc	Attending Physician: r death. ector: After this certific. by the funeral director,	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 ∐ No	28d. Describe r	low injury occurred	
isi	Attendeath death ctor:	ficat	3 Suicide 6 Could not be	28e. Place of injury - At h			100 2	28f. Location (S	Street and Number o	r Rural Route Number,
2	al or safter	Certification:	4 ☐ Homicide determined	building, etc. (Special	fy)			City or Tow	ın, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical (sician: To the best of my knoner: On the basis of examination and manner stated.						
	To ti withi To ti comp	ğ	29b. Signature and title of certifier	///		29c. Licens	e number	1	29d. Date signed (M	fonth, Day, Year)
			Cont	m		05	8824		6/12/	08
			30. Name and address of person who co	nov 119	<u> </u>	Print) Macs	n St	Galar	ig Mo	21635
100			31. Date filed (Month, Day, Year)	32. Register's Sign:						

DHMH 17 Rev 1/2001

72 hours after death with Maryland 21215-0036 Pages 1 and 2 Baltimore,

attending physician and for use as the burial-trar been signed by the should be detached Records, cate has this certificate Vital Physician: director, of

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 06 Marie Welch 2008 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICIM 100 ROSIANAL SALISBUM If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛛 F Months Days Hours Director 219-56-8543 5-11-1951 Delaware Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Show 10a. State 10b. County If of Health and Mental Hygiene.
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To the Funeral Director:
completely filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			L_ State	ite of Maryland		rtment of F				
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	lineate or		2. Date of Death	g. No. 200	8 3 Tipe (0.85)
	sicia		Peiling Zhao					June 07	Day Year	8:15 P M
	ledica amine		4a. Facility Name (If not Institution, give street a	and number)		4b. City, Town, o	r Location of Death	0	4c. County of Death	
_ *		"	212 Garth Terrace			Gaithe	rsburg		Montgom	ery
Fund			5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. la 80	<i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 4)	Year) Cou	nplace (State or Foreign intry) nina
			Usual Residence of Decedent						,	
rylan s how	Til I	_	10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
e Ma 8a-f	N N	Director	MD Montgomery		aithe					1 ☐ Yes 2 🖾 No
vith th	2		10e. Street and Number			10f. Zip Code	0		g. Citizen of What Cou	
eath v	THE STATE OF	era	212 Garth Terrace	as Decedent Ever in U.S	12.14	2087			Jnited Stat	
DaitIIIIOre, Iviary liand 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	zaciicari	by Funeral	1 Never Married 2 Married 1 If Y	as Decedent Ever in 0.5 med Forces?]Yes 21XINo 'es, Give ar or Dates:		Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	Black, White	etc.
Z I 3-UUSO hin 72 hours af e. an "natural", or	Call		15. Decedent's Education		16a. Deced	ent's Usual Occup	pation	. 10		
within 7: ene. than "n	E Med	Completed	(Specify only highest grade comp	llege (1-4or 5+)		and of work done O NOT use retired urse	during most of work d)	ing	Health Ca	are
filed Hygi	ent, I		17. Father's Name (First, Middle, Last)		211	urbe	18. Mother's Nam	e (First, Middle, Ma		210
yland buld be file Mental Hy arked oth	atic ev	To Be	Shi Guang Tong				Shiu Ch			
INIAI nd 2 sh alth and 27 is r	r traum	1	19a. Informant's Name/Relationship (Type. Pri. Ning Yeh (Daughter)	int)		•			City or Town, State, Z $c_{ m g}$, MD $c_{ m s}$	
es 1 ar of Hea	r offie		20a. Method of Disposition	20b. Pla		sition (Name of atory or other place			Oc. Location - City or T	
altimor rmit. Pages spartment of portant: If it	o fund		1 ☐ Burial 2 ♣ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	ai from State I	opoli	tan Crema	atory 20	08 A	Alexandria	, VA.
Depariment	any in		21. Signature of Funeral Service Licensee	berg			^{ess of Facility} De er Park D		cal Home thersburg,	MD. 20877
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	s that aused the death. se of each line.	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
Physic /Medí	_	1		yocardial I		ion				Onset and Death
Exami	_		T T	Due to (or as a conseque						
P :		ne		iabetes Mel Due to (or as a conseque						
ecuter	-transi	Examiner	that initiated events C. 11	ypertension Due to (or as a conseque						
icate be executed physician and	DOLLIB	dical E		Due to (or as a conseque	ance or).					
	as me	edic	d							
eath certific	nse	sician/Me	23b. was decedent pregnant	res, outcome of pregnan ☐ Live birth 2☐ Fetal o		Ectopic pregnance	***		23d. Date of deli	
requires that the death certification signed by the attending	Deu iol	hysicia	1 \(\text{Vos } 2 \) \(\text{Mon}\)	Pregnant at time of de		Other (specify)			Month	Day Year
that i	dela	٥.	Part II. Other significant conditions contribution	ng to death but not result	ting in the un	derlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
requires that the de speed by the	a ping	ed by						1 ☐ Yes	s 2 K No 3□ Pro	obably 4 🗌 Unknown
ne law re	2 1	ompleted						24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of
The The icate h	, page	Š						performe	ed? death?	2 A No
ysician: The law lis certificate has		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣No Hospita	ll: 1 □ Inpatient 2 □ E	:B/Outpatient	3 DOA Oth		th (Check only one)) nce 6 □Other <i>(Sp</i> ec	sife)
ng Phy	=	on: To	AND THE RESERVE OF THE PARTY OF		28b. Time of Injury	28c. Injui Wor	ry at k?	28d. Describe how		my)
Attending or death.	me iuneral	catic	2 Accident investigation			M 1 □	Yes 2 □ No			
al or Att	<u> </u>	Certification:	4 Homicide determined 28e	 Place of Injury - At hon building, etc. (Specify) 	ne, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has been applied to the Funeral process.	- 1	Medical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: O ar	To the best of my know In the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the ti restigation, in my o	me, date and place opinion, death occu	, and due to the car rred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
To th To th	шоз	Me	29b. Signature and title of certifier	· 24.	1-	29c. Licens	se number	29	d. Date signed (Month	n, Day, Year)
11				WHO, PHY			369	J	une 09, 20	008
V			30. Name and address of person who complete				to D Ma	rth Doto-	ac MD 20	1878
	Stat	2	Nelson L. Lui M.D. 1 31. Date filed (Month, Day, Year)	1908 Darnes 32 Registrar's Signatu	re		LLE D, NO	LII FOTOM	iat, PID. 20	70 / 0
Re	gistra	~	JUN 12 2008	Received to	600	all s				

			1 - State Registrar	State of Maryland / De	epartment of Hea Certificate of De	ulth and M eath	R	eg. No.	20857
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	aun			2. Date of Deal Month	Day D'ear	3. Time of Death 62051 _M
	Examir Funeral Director		1 10 1: ·	11111	Months Days H	Under 24 Hrs.	8. Date of Birth (Month, Day,	4c. County of Death	place (State or Foreign
	Maryland -f show ited at	tor	Usual Residence of Decedent 10a. State 10b. County HOLFOR	d Fore	11211		· · · · · · ·		10d. Inside City Limits 1 ☐ Yes 2 No
	h with the	Funerai Director	10e. Street and Number	1 Drive	10f. Zip Code 2105	D	1	0g. Citizen of What Cou	intry?
5-0036	in 72 hours after death with the Maryland "natural", or Itams 23a or 28a-1 show bolical Exercited: sast be neillied at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispa If Yes, specify Cuban, N 1 ☐ Yes 2 No S	nic Origin? (Sp fexican, Puerto pecify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
0-C1212	I within 72 lene. r than "na	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (C	ecedent's Usual Occupation live kind of work done during fe. DO NOT use retired)	n ng most of work		16b. Kind of Business/li	Motors
/land	shoutd be filed ind Mental Hygis is marked othar umatic event, I	To Be C	17. Father's Name (First, Middle, Last)	OMU	18.	Mother's Name	e (First, Middle, I	Maiden Sumame)	
, Mar	s 1 and 2 should f Health and Mer itam 27 Is marke other traumatic		19a. Informant's Name/Relationship (Ty, Mrs. Claudia W	IKins doughter 190	lailing Address (Street and	Drive F	crest Hil	11, md 210	50
altimore,	Ø O L		20a. Method of Disposition 1 Burial 2 Commation 3 Records 4 Contains 5 Other (Specify)	remetery	isposition (Name of crematory or other place)	6/27	12008	20c. Location - City or T	llik
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	Evais	22. Name and Andress of Services 3 Newport Dri	ve For	est Hill	, md 210°	50
	Pnysician	- 24	shock, or hear failure. List only on Inmediate Cause (Final disease or condition			secondiac		est,	Approximate Interval Between Onset and Death
	/Medical Examiner	_	resulting in death) Sequentially list conditions,						
\$ '09/80	ficate be executed g physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last	Due to (or as a consequence of) Due to (or as a consequence of)					
O. BOX 68	death certi e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliver Month	very Day Year
ds, F	requires that the de een signed by the a nould be detached f	ρλ	Part II. Other significant conditions con	tributing to death but not resulting in th	ie underlying cause given in	Part I.	23e. Did tol	bacco use contribute to	
vital Records,	The law ate has b bage 2 sl	Completed					24a. Was a autops perform	y prior to c	opsy findings available ompletion of cause of
	ysician s certifi director	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	04	-	n <i>(Check only on</i> me 5 ☐ Reside	ne) ence 6 □Other (Spec	īfy)
on or	nding Physician: th. The this certific funeral director.	atlon: T	27. Mann P Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Injury at Work?	2 □ No		ow injury occurred	,,
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifical completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office		28f. Location (St City or Town	treet and Number or Ru n, State)	ral Route Number,
	e Hospi 24 hou a Funar etely fill	edical		ician: To the best of my knowledge, o er: On the basis of examination and/o and manner stated.					
	To the within To the compl	Me	29b. Signature and title of certifier	1.0	29c. License nu		2	9d. Date signed (Month	Day, Year)
	12		30. Name and address of person who con	npleted cause of death (Item 23a) (Ty	pe, Print)	ninster	md ?		
	Sta		31. Date filed (Month Day, Yan) 201	32 Hegistrar's Signature	Anastes	11.12.1.	11.00		

			1 - For State Registrar	ate of Maryland	/ Depa	rtment of F	lealth and N Death	/lental Hy	giene 200	8 20858
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physicia		Norman R	Re	rgero	n		June 1	7. 2008 Ye	6:25 P M
an la	/Medic Examin		4a. Facility Name (If not institution, give stree		18010		Location of Death		4c. County of [Death
a series	Examin		St. Mary's Nursing H	ome		Leonard	town		St. Mar	y's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	v. Year)	Birthplace (State or Foreign Country)
	Director		015-01-2374	^{2⊔ F} 90	Yrs.	Wioriano Dayo	110010	April 7	, 1918 Ha	verhill, MA
	p ,		Usual Residence of Decedent 10a, State 10b, County	100 City	Town or Loc	nation				10d. Inside City Limits
	aryla shov	'n		,						1∭Yes 2□No
	he M	Directo	Maryland Saint Mary 10e. Street and Number	s Leon	ardto	wn 10f. Zip Code			10g. Citizen of Wha	t Country?
	a or					20650			U.S.A.	Country
	eath rs 23	Funeral	21585 Peabody Street	Vas Decedent Ever in U.S.	13 V		isnanic Origin? (Sr	pecify Yes or No		American Indian,
	ter d	Fun	1 Never Married 2 Married 1	rmed Forces? [X]Yes 2 □ No] 940	į.		ispanic Origin? (Sp nn, Mexican, Puerto	Rican, etc.)		Vhite, etc.
8	urs al	by		Yes, Give ear or Dates: 1945	1	□Yes 21\(\infty\)No	Specify:		Specify: W	hite
9	2 hor	Completed	15. Decedent's Educatio		16a. Deced	ent's Usual Occup	ation during most of work	rina	16b. Kind of Busin	ess/Industry
7	thin 7 e. an "r	nple.	(Specify only highest grade cor	College (1-4or 5+)	`life. E	OO NOT use retired	i)	ung		
7	od wit /gien er th	ő	7		Opera	ting Eng			Constru	ction
nd	be file tal Hy doth event	Be	17. Father's Name (First, Middle, Last)					•	Maiden Surname)	
$\frac{8}{2}$	Men arked	ဥ	Raoul Bergeron				Anna Car			
<u>a</u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Madical Exeminations has notified at		19a. Informant's Name/Relationship (Type. F	, i		•			er, City or Town, Sta	ite, Zip Code)
<u>0</u>	and Health I'm 27 I'm t		June Briggs (Daught			Box 420 sition (Name of	Solomons,	MD 206	20c. Location - Cit	v or Town State
0	ges 1 If ite or of		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Remo	cen	neterv, crem	natory or other place ar Hill	e) 6/21			
Baltimore, Maryland 21215-0036	t. Pa rtmer rtant: rjury		4 ☐ Donation 5 ☐ Other (Specify)		tery			•	Philadelp	olita, FA
Ba	permit. Pages 1 and 2 should be flied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercites must be notified at once.		21. Signature of Funeral Service Licensee	onde			ss of Facility Ener Fune			DA 10125
			23a. Part 1. Enter the disease, or complication	ons that caused the death.						PA 19135 Approximate Interval Between
			shock, or heart failure. List only one ca	use on each line. 🛔		A		9177		Interval Between Onset and Death
and the second	Physician /Medical		disease or condition resulting in death) a	Due to (or as a conseque		prost	7	91.310	71	-
	Examiner			(0 20 N		A .	diseo	ne		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequer						
19.	cutec nd ransit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	CH	FV					
Ö,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):					
8760,	cate to physic the p	dical	d							
9 ×	ding p	Me	IF FEMALE:	f yes, outcome of pregnanc	21/				00 / 0-4-	4.1.1
Вох	eath certific attending p for use as	sian	in the past 12 months?	1 ☐ Live birth 2☐ Fetal d 1 ☐ Pregnant at time of dea	eath 3	Ectopic pregnanc Other (specify) _	у		23d. Date of Month	
o l	uires that the de signed by the a d be detached f	Physician/Me		Unknown		z curior (opeony) _				
σ.	that ned by deta		Part II. Other significant conditions contribu	iting to death but not resulti	ng in the ur	derlying cause giv	en in Part I.	23e. Did t	obacco use contribu	ite to the cause of death?
g.	quires n sign	d by						1 🗆	Yes 2 □ No 3[☐ Probably 4 Unknown
ပ္ပ	w requir s been s should	Completed						24a. Was	an 24b. We	re autopsy findings available or to completion of cause of
œ	The law te has age 2 a	omp						auto perfo 1 □ Yes	rmed? dea	
<u>a</u>	an: rtifica tor, p	Be C	25. Was case referred to medical				26. Place of Dea			iles ZEINO
>	nysic nis ce direc		examiner? 1 Yes 2 No Hospi	ital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatien	t 3 DOA Oth	er: 4 🖾 Nursing H	ome 5 ☐ Resi	dence 6 Other	(Specify)
0	ding Physician: The I h. After this certificate he funeral director, page i	L:uc	27. Manner of Death 2 1 📉 Natural 5 □ Pending	8a. Date of Injury 2 (Month, Day, Year)	8b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury occurred	
0.0	endii eath. or: A the fu	catio	2 Accident investigation				Yes 2 □No			
Division of Vital Records,	or Attendatifier death	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 2	 Place of Injury - At hom building, etc. (Specify) 	e, farm, stre	eet, factory, office		28f. Location (City or To		or Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Physicia	n: To the best of my knowl	edge death	occurred at the ti	me, date and place	and due to the	cause(s) and man	ner as stated
	Hos 24 hc Fun etely	Medical		On the basis of examination and manner stated.						
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (/	Month, Day, Year)
) Alghal	1		D	470G	6	6.1	8.8
	0		30. Name and address of person who comple	eted cause of death (Item 2	23a) (Type, I	Print)	. , , - 0			<u> </u>
	8		A.D. Shah, MD	21585 Peabod	y St.	, Leonard	ltown, MD	20650		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re					
	Registr	ar	.UIN 2 7 2008	Backer St.	1000mg	V				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 20859 For State Registra Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oak Crest Care Center Parkville. Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 1/16/1915 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1X M 2 □ F 93 212-01-6883 Yrs Pennsýlvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28e-f show the Medical Examiner must be notified at MD Baltimore Parkville 1 ☐ Yes 2X No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? B800 Walther Blvd. 21234 Apt. 1112 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 □XYes 2 □ No If Yes, Give UWII Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: þ White Maryland 21215-003 3X Widowed 4 ☐ Divorced nature Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) CPA Accountant other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H ie marked ot permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked any injury or other traumatic eventee. Ida Roberts Jav Miller Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay R. Bell / Son 3517 Waverly Drive Fredericksburg, VA 22407 timore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State MXBurial 2 ☐ Cremation 3 ☐ Removal from State 6/30/2008 Parkville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a conseque Box 68760. physician Physician/Medical the ' IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 3 DOA 1 Inpatient 2 ER/Outpatient ihis After this funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? Injury Natural 5 Pending after death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 30. Hame and address of person who completed cause of ath (Item 23a) (Type, F 8800 MI 32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Jimmy Dee Box 25, Jr. 2008 June 6:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7980 Old Telegraph Road Severn Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 7, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Months 248-50-4768 74 Director 1934 MO Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director MD 1 ☐ Yes 2 No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7980 old Telegraph Road 21144 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ⚠ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 if Yes, Give Year or Dates 1 ☐ Yes 2 X No þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jimmie Dee Box, Sr. Frances Triola 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st
Department of Health an
Important: If item 27 is r
any injury or other traur Mrs. Helen Farnen /Daughter 10505 Chester Way Woodstock, Maryland 21163 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 30. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD Maryland Vets. Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Smo **Physician** Luag disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Yes 2□ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has this certificate 2 🗆 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 727938 June 25,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uospital Prive Glen Burne, MD 21061 31. Date filed Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month AM 08 SUSAN MARIE BOESHORE 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore OSedale 1 Year | If Under 24 Hrs. guare Hospital 8. Date of Birth (Month, Day, Year) SEPT. 21,1961 5. Social Security Number In yrs. last birthday) If Under Days Hours 1 □ M 2 🛣 F 220-88-1363 SEPT. MD 46 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 USA 8225 OLD PHILADELPHIA RD Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **EXECUTIVE SECRETARY** UNIVERSITY OF MD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **BROOKS** MYRICK MARY LOUISE WRIGHT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROBERT BOESHORE-HUSBAND 8225 OLD PHILADELPHIA RD BALTIMORE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 6/21/08 BALTIMORE, MD f Foneral Service Licensee 22. Name and Address of Facility 21. Signature MILLER-DIPPEL FUNERAL HOME, INC 6224 BELAIR RD BALTIMORE, MD 21206 Part1. Enter the disease, shock, or heart failure. 23a. Part1 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): rho 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hopho Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 23e. Did tobacco use contribute to the cause of death? 1;☑ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed2 1 Yes 2 ☑ I 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

items 23a or 28a-f shov ner must be notified at

If item 27 is marked other than "natural", or iten or other traumatic event, the Medical Examiner

I Hygiene. other than "

12 should be filed whand Mental Hygien Is Is marked other to

. Pages 1 and 2 should be timent of Health and Mentalant: If item 27 is marked

permit. Page Department o Important: If any Injury or

Director

Funeral

Completed by

Be

death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Box 68760,

Division or Vital Records,

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificd completely filled in by the funeral director,

The law requires that the death certificate be executed

and

attending

has page 2

certificate

for

Examiner Physician/Medical ò Completed Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

examiner?	?	to medica
1 ☐ Yes	2/2/No	

28a. Date of Injury (Month, Day Year)

and manner stated.

5 ☐ Pending investigation 2 Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

Drive, Baltimore

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Square 000 Franklin

31. Date filed (Modth, Day, Year)

29a. Certifier

Medical

State

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 20862 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 22:25 PM Haron 2008 1. JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Year) 1 M 2 □ F Months Hours 249-86-8110 Director 06-Usual Residence of Decedent Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" --- and injury or other traumatic events. 10a. State 10c. City, Town of Location 10d. Inside City Limits 1 Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married 1 ∐Yes 2 If Yes, Give Year or Dates: 2 No 1 ☐Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19a, Informant's Name/Relationship (Typ ... Print) 19b. Mailing Address (Street and Number or Rural Route Number, Town State 20b. Place of Disposition (Name of cemetery, crematory or other page 200). 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1411 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician urosepsis /Medical Due to (or as a consequence of): Examiner HOUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last of as a gense Examine The law requires that the death certificate be executed tastatic burial-trai Due to (or as a consequence of): P.O. Box 68760, physician the burial Physician/Medical attending p IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 5 ☐ Other (specify) □Yes 2 □ No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🕰 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an certificate has 2 No 1 □Yes To the Hospital or Attending Physician: 'within 24 hours after cleath.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No P T⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 JUNE 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amanda Tittanx MD 4940 EASTERN AVENUE BALTIMORE, MD 21224 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

			For 1 _ State	State of I	Marylar		artment of H		Mental Hy	giene				
		_	Registrar	- 43		Cei	rtificate of	Death	1 0 D 11 11 D	Reg. No.	2008	3,20863		
	Physici	an	1. Decedent's Name (First, Middle, La Ruth Frances Burd	•					2. Date of De Month June 2		Year	7:50 P. M		
safe.	/Medic Examin		4a. Facility Name (If not institution, giv		er)		4b. City, Town, or	r Location of Deat		4c. County of Death				
-	Examin	ei	Manor Care Potoma		,		Potomac				ntgomer			
1,000	Funeral		Social Security Number 6. S	ex 7.	Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth	9 Birth	nplace (State or Foreign		
В	Director		219-12-4705	☐ M 2 🛣 F	83	Yrs.	Months Days	Hours Will.	Jan. 2	ľ, 19	25 Mary	Tand		
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits		
	Maryla f sho ed at	or	Maryland Montgome	rv	Poto							1 □ Yes 2 ☑ No		
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	death	Funeral	11. Marital Status	12. Was Decede	ent Ever in U	I.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No		4. Race - Amer	ican Indian,		
တ္တ	after or ite		1 Never Married 2 Married	1 ☐ Yes 21 If Yes, Give			1 ⊡Yes 21£ No	Specify:	to Hicari, etc.)		Black, White Specify:			
8	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	d by	3X Widowed 4 □ Divorced	Year or Date	es:							White		
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Maryland	2 should be filed w n and Mental Hygie Is marked other ti raumatic event, th		19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street	and Number or Ri	ural Route Numb	ber, City or	Town, State, Z	ip Code)		
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Patricia L. Rober	ts / Nie			Portree							
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	5		30. Name and address of person who S.M. Nayar MD,				cage City	MD 207	22					
	Sta	te	31. Date filed (Month, Day, Year)	2. Reg	istrar's Signa	ature	A R	. / ۷۷ مند و						
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O. Box 687	law requires that the death certificate be e. as been signed by the attending physician 2 should be detached for use as the buria	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2	nonths?	1 0 1	Live birth	of pregnand 2 ☐ Fetal d t time of dea	leath 3	Ectopic pr Other (spe		′			_	23d. Date of		ry Day Year
۳.	that the dended by the detached		Part II. Other signific	cant conditi	ons contributina	to death be	ut not resulti	ing in the un	derlying ca	ause give	n in Part	1.	23e. Di	d tobacco	use contribi	ite to the	e cause of death?
Division of Vital Records,	quires tha n signed ald be det	d by	4 1	1 .	Demen								11		W		ably 4 🗆 Unknown
၀၁ေ	aw requii as been s 2 should	Completed	His Fre	ictur	e Pelu	icF	racti	1(e.	Coron	ary	Arte	ery	24a. W				sy findings available
<u>۳</u>	The law ate has page 2 s	Com	Disease,	COng									au pe 1 □ Ye:	topsy rformed? 2 K No	dea	or to con ith?]Yes	npletion of cause of
/ita	ician: sertific setor,	Be (25. Was case referre				1411		-			e of Deat	(Check onl		<u> </u>		
of	Physical this call direction	.T	1 Yes 2 □ N 27. Manner of Death	10			ent 2 EF				4 LA N	lursing Ho	me 5 Re	esidence	6 ☐ Other	(Specify)
on	iding th. After funer	tion	1 Natural 2 Accident	5 Pendin	ng (Date of Inju Month, Day	y, Year)	8b. Time of Injury	M 28	8c. Injury Work 1 □ \	rat ? ∕es 2 🛣	4	28d. Describ out of	e how inju	ıry occurred e 1chai	Prol	bable fall
visi	Atten ar deal ector: by the	Certification: To	3 🗋 Suicide	6 Could determ	not be	lace of Inju	ury - At hom c. (Specify)	1	_				28f. Location	(Street a	n <i>d Number</i> (or Rural	Route Number,
Ö	tal or rs afte al Dir ed in	Cert	4 Homicide				de Val				10		Walk	own, Stat	176 M	Er	ederick St
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:		(Check only 2	Certifyir	ng Physician: To Examiner: On t	the best of	of my knowled f examination	edge, death n and/or inv	occurred a	at the tim	ne, date a	and place, eath occur	and due to t	he cause(s) and mann	er as st	ated. the cause(s)
	o the rithin 2 or the ormple	Medical	one) 29b. Signature and ti		and	manner sta	ated.			. License					ate signed (/		
	1 3 1 8			ton		N ()		0 - 0	D	511	43			200. 00	and digital (no Ch	100.7
	L	-	30. Name and addre	ss of person			130 (Item 2		Print)	711	073				20	VÖ	
	۲		65C	Tho	mas I	John.	son l	rive		trec	teri	CK	Mi)			
	Sta Registra		31. Date filed (Month	JUN 2	7 2008	2. Registra	ar's Signatur	e K	rede	0							

08-04690 Kenyatta Boodram

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 20865

		1- For State Registrar Certificate of I	Death	Rec	2 U U g. No.	8 2086		
Physicia		Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death		
Medical Exami	ner	KENYATTA GENEA BOODRAM		Month June 18, 20		0033 hrs		
		4a. Facility Name (if not institution, give street and number) 4b. Prince Georges Hospital	. City, Town, or Location of Deat Cheverly	Death 4c. County of Death Prince George's				
F				n Data of Dist				
Funeral Director			If Under 1 Year If Under 24Hs Months Days Hours Mi	n. Foreign				
500.01		578-21-2261 1 M 2XF 17 Yrs.		05-19	–1991 ^{Col}	intry) DC		
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	·			10d. Inside City Limits		
			,			1 X Yes 2 No		
daryland 28a-f show 1 at once.	یز	MD Prince George's Clinton 10e. Street and Number	101 7 0 1	·		-		
with the Maryland ms 23a or 28a-f sho be notified at once.	Director		10f, Zip Code	10	g. Citizen of What Coun	try?		
ith the		5928 East Boniwood Turn	20735		USA			
eth wi	neral		Decedent of Hispanic Origin? (\$, specify Cuban, Mexican, Puert		14. Race - Americ White, etc.	an Indian, Black,		
er der , or i	F	1 Yes 2 X No	es 2 X No specify:		, p1	ack		
ural' mine	by	or Dates:	Usual Occupation (Give kind of	work done	Specify: B1 16b. Kind of Business/Ir			
2 hou	Completed		t of working life. DO NOT use re		rob. Kind of business/ii	laustry		
36 hin 7 e. than edica	힏	11th Student			Education			
d with year other he Me	5	17. Father's Name (First, Middle, Last)		ne (First, Middle, M	Education aiden Surname)			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be (Shuna Boodram	Kimber	ly Ballar	rd			
21. ould bould by Men	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Address (Street and Number or	Rural Route Numb	per, City or Town, State,	Zip Code)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Kimberly Ballard / Mother 8684	SCORTON HARBOUR	R PASAD	ENA, MD 21	122		
Te, l and l Heal		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or othe		Date	20c. Location - City or	Town, State		
Pages ent ol	Ш		norial Park 06	_23_2008	Landovar	MD		
Baltimore, bemit. Pages I an Department of Hea mportant: If iter		21 Sharphage of Foneral Service Ideensee 22. Nat	me and Address of Facility MA	RSHALL'S	FINERAL HO	ME OF MD		
E E E E		Donald R. Gray	4308 SUITLAND R	ROAD	SUITLAND, N			
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the allure. List only one cross on each line.	mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and		
/Medical	- 1	Mediate Cause (Final di Vase a. Gunshot Wound of Torso				Death		
xammer	- 1	or condition resulting in death) Due to (or as a consequence of):						
-	اير	Sequentially list conditions, if any, leading to immediate b						
	Examiner	cause. Enter Underlying Cause						
_ 1 =	ğ	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
and transit	జ	d						
ial e	edical	UNPENDED AMENDED						
	≥1	IF FEMALE: 23b. Was decedent pregnant in the			23d. Date of delivery			
Ox 68 ath certif attending or use as	sician	past 12 months?	death 3 Ectopic pregr	nancy	Month D	ay Year		
Box 687 e death certifuthe attending	ysi	1 Ves 2 No 9 Unknown 9 Unknown	r (Specify)					
3. € €	Phy	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?		
P.O. res that the signed by be detac	d b			1 Yes	2 No 3 Prob	ably 4 Unknown		
rds requi	Completed			24a. Was ai		opsy findings available		
e law e has ge 2 s	g.			autops	ned? death?	empletion of cause of		
tal Recian: The		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 ✓ Ye	2 No		
of Vital Records, in Physician: The law require the this certificate has been simeral director, page 2 should be	Be	examiner?	IOther:		Residence 6 Other:			
n of \ ing Phy After th	음	27. Manner of Death 28a. Date of Injury 28b. Time of Injury			ow injury occurred			
ath. Fr: A	틸	1 Natural 5 Pending Jun 17, 2008 2338 hrs	1 Yes 2 ✔ No	Subject shot				
Division tal or Attendi rs after death. al Director: /	ig	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	factory, office building, etc.	28f. Location (St	reet and Number or Run	al Route Number, City		
DIVISOSPITATION /	Certification:	3 Suicide 6 Could not be determined (Specify) Parking Lot		or Town, Sta				
Hosp 24 hos Fune tely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre	d at the time, date and place, an		***********			
Di To the Hospital within 24 hours a wither Funeral I	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.						
F * F 8	ã∣	29b Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)		
		(A andersul)	O.C.M.E.		June 18, 2008			
2	+	30 Name and address of person who completed cause of death (Item 23a)	<u> </u>					
2		Laron Locke MD. Assistant Medical Examiner 111 Penn S	treet, Baltimore, MD 212	201				
Sta		31. Date filed (Month, Day, Year)						
Registi	rar	JUN 2 7 2008 Janes & Spark	F					
DHMH 17 Rev 1/20	01	ÖRIGINAL						

Amend Item State of Maryland Department of Health and Mental Hygien 2008

Amend Item 19a per In, 880,06/2/08dhb

Reg. No. 20866 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 9 3004 /Medical 4a. Facility Name (If not institution, give street and nu 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Athol Future Care If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1₩ 2□F Yrs. Director 6-23-1971 36 219-84-9032 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Show rthen "neturel", or Items 23e or 28e-f shov tre Medical Examiner must be notified at Yes 2 No Director Baltimore MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA death v 911 Homestead Street 21213 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or Ite any injury or other treumetic event, the Madical Examina 9008. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black δ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marsha Brooks James F. Byrd, Jr 19a Informant's Name/Relationship (*Type, Print*) **Marsha Byrd** Marcia Byrd-Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21202 725 Fallsway 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Qurial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) 6-30-2008 Randallstown, King Memorial Pk 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 200 1101 E. North Avenue Balto, MD 21202 wan 23a. Part1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of). Examiner es Z Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine led by the attending physician and detached for use as the burial-transit law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? Yes 2 No certificate 1 🗌 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner?
Yes 2 □ No Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOFRE mD 21229 32. Registrar's Signature NISHA Baltimore 31. Date filed (Month, Day, Year) State Registrar

			1 - State of Maryland / Department State of Maryland / Department Certificate	t of Health and N e of Death		ene g. No. 2008	20867
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medic		ROBERT ADOLPHUS BURKE		JUNE	25, 2008	3:15 P.™
	Examin	er		Town, or Location of Death		4c. County of Deat	
	Funeral		7872 ROLLING VIEW AVENUE NO 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	TTINGHAM 1 Year If Under 24 Hrs.	8. Date of Birth	BALTIMON 9. Birt	hplace (State or Foreign
	Director		218-14-5695 1X M 2□ F 84 Yrs. Months	Days Hours Min.	(Month, Day, 2/24/192	Year) Co	uintry) YT.ANID
	pu ,		Usual Residence of Decedent			J. T.IAU	
	aryla shov	or.	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	rect	MD BALTIMORE NOTTINGHAM 10e. Street and Number 10f. Zip	Code	10	g. Citizen of What Co	••
	3a or	Ö					
	death	Funeral Director		1236 lent of Hispanic Origin? (Sp ify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Ame	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amyl injury or other traumatic event, I'm Michal Evanther must be notified at once.		1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced Year or Dates WWII		Hican, etc.)	Black, White Specify:	white
5-0	72 ho natur	Completed by	15. Decedent's Education 16a. Decedent's Usua	d Occupation	ina 1	6b. Kind of Business/	ndustry
121	ithin ne. han "	mple	Elementary/Secondary (0-12) College (1-40r 5+)	k done during most of worki e retired)			
22	Hygie Hygie Ither t		4 YEARS INDUSTRIAL 17. Father's Name (First, Middle, Last)	L ENGINEER 18. Mother's Name		AMERICAN S	STANDARD
an	d be fental ked o	To Be	CHARLES A. BURKE			aiden oumane)	
ary	shoul and M marl	ř		ADA PI (Street and Number or Run		City or Town, State, 2	ip Code)
ž	and 2 saith a		MARGARET B. BURKE/WIFE 7872 ROLL	TNG VIEW AVE.	NIOTTTN	ICHAM MD	21236
ore	of He		20a. Method of Disposition 20b. Place of Disposition (Nam cemetery, crematory or of	ther place)			
<u>=</u>	: Pag tment tant:	ļ	4 □ Donation 5 □ Other (Specify) PARK WOOD CEME			BALTIMORE,	
Bai	permit Depar Impor any in once.			d Address of Facility THE OCH RAVEN BLV			HOME, P.A. 1286
			23a. Part 1 There the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	e of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				Onset and Death
	∞/Medical Examiner		resulting in death) Due to (or as a confeduence of):				
		-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
/	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncerhaig Cause (Disease or injury that initiated events			53	
, 0,	an an	Exa	resulting in death) Last Due to (or as a consequence of):				
68760,	tificate be executed g physician and as the burial-transit	edical	d				
			IF FEMALE:				_
Вох	Attending Physician: The law requires that the death cer rideath. After this certificate has been signed by the attendir by the funeral director, page 2 should be detached for use	Physician/IV	23b. Was decedent pregnant in the past 12 months? 1 Ves. 2 No. 4 Pregnant at time of death 5 Other (spe.			23d. Date of del Month	ivery Day Year
P.O.	uires that the de	ysic	1 Yes 2 No 9 Unknown 9 Unknown	(City)			
ώ. σ	s that med b e deta	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	ause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ğ	tw require s been sig should b	ed b			1 ☐ Yes	2 No 3 Pr	obably 4 🗌 Unknown
Vital Records,	elawre hasbe je 2 sho	Completed			24a. Was an autopsy		topsy findings available completion of cause of
<u>~</u>	Physician: The la	Con			perform		
Vita	certifi ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death	(Check only one		
of	Phys r this ral dir	5	I Inpatient 2 EH/Outpatient 3 DO		me 5 Resider 28d. Describe hov	ice 6 Other (Spe	city)
on	oding th. : Afte : fune	ţi	Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation M	Bc. Injury at Work? _1 □ Yes 2 □ No	200. Describe nov	injury occurred	
Division of	tal or Attending Phy s after death. al Director: After this ed in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could not be		28f. Location (Stre	et and Number or Ru	ral Route Number,
Ó	tal or s afte al Dir ed in	Cert	4 ☐ Homicide building, etc. (Specify)		City or Town,	State)	
	To the Hospital or A within 24 hours after To the Funeral Directory filled in by	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred a plant of the basis of examination and/or investigation, and manner stated.	at the time, date and place, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To th To th comp	Me		. License number	29	d. Date signed (Monti	n, Day, Year)
3.			> Styll MD	059359		5/26/08	
	4+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
سنو			Raymond Zollinger, MD 4924 Campbell Blvd. 31. Date filed (Month, Day, Year) 2. Registrar's Signature	White Mars	h, MD 2	1236	
	Stat Registra		31. Date filed (Month, Day, Year) 2. Registrar's Signature JUN 2 7 2008				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 24, LENORE JMR 2008 BERMAN 11:53PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City, Town, or Location of Death Examiner GILCHRIST HOSPICE CARE TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth Month, Day, Year) 3/24/1926 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF Months Days Hours Min 193-22-1856 82 PA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Fysical Processing 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Director BALTIMORE OWINGS MILLS 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9401 WORDSWORTH WAY, #404 21117 USA Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, 1 Never Married 2 Married WHITE 1 ☐Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS PAULL MARY **GELMAN** ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAROLD BERMAN / HUSBAND 9401 WORDSWORTH WAY, #404 OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CEM. 6/27/2008 REISTERSTOWN, MD 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rast Cancer MOVITAC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. First and the cause of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the burial Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 18 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \(\text{VOS PLC4} \) 1 Tes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 27. Manner of Death Certification: 28a. Date of Injury (Month, Day, Year) 28b. Time of the Hospital or Attending P thin 24 hours after death. the Funeral Director; After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

VARON

CHARVES

Name and address of person who completed cause of death (Item 23a) (Type, Print)

W 6701 32. Registrar's Signature

29c. License number

nerces

29d. Date signed (Month, Day, Year)

2008

JUNE 25

am NORMEL

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 18 per inf g883 9-4-08 vt. State of Maryland / Department of Health and Mental Hygiene | State Registrar Amend #1 perMD, 9880 6/30/08 TT | 1. Decedent's Name (First, Middle, Last) | Margaret Mary Barry Certificate of Death 2. Date of Death Month JUNE ₽ay. **Physician** MARGARET 56998 11:43AM MART BARRY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day Year) | Oct. 15, 1913 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2XX Marvland 216-07-6150 94 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dipartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Modical Examination 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 💥 O Director Maryland | Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road #1211 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1XXNever Married 2 ☐ Married 1 □Yes XX No Specify: White If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Aloysius Barry Mary Frances Spell-Fell ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5124 Arrowhead Lane Plano Texas 75093 Niece Karen Barry Boyd 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Most Holy Redeemer 6/30/08 Baltimore, Maryland gnature of Funeral Service kicense 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MYOCARDIAL INFARCTION ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 5 Other (specify) 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completely filled in by the funeral director, page 2 should be detailed. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performs 2 **X**No 1 □Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) elon, M.D. June 26,2008 DØØ17695

Registrar
DHMH 17 Rev 1/2001

7601 OSLER DRIVE

TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year) JUN 2 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 24a, 4c per dr. 880,06/2/08dhb

Reg. No. 20870 Reg. No 2008 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Year 4a. Facility Name (If not institution, give street and num 7 30 AM mó rooper 2003 /Medical **Examiner** 4b. City. Town, or Location of Death 4c. County of Death and Sta easons Baltimore 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min 1 □ M 2 □ F Months Days Hours 219-03-462 **Director** 16-1920 Usual Residence of Decedent permit. Pages 1 and 2 shr ud be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other trauming event, the Modest Expined into the profession. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MI Baltimore 14⊒Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Silverthane ho 21239 U.S.A Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married Yes, Give 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 I No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept of Educat Engineer 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) rillian ooper Clark ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4504 Winlee Pd Pardallstown Mi) 2113co of Disnosition (Name of Date 20c. Location - City or Town, State <u>C.</u> 21137 Brewda 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6.27.208 Baltimore, MD Baltimore National 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Caugh C. Greene Funcion Services 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York Ad Baitimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atherosclerotic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a surresquence of) or Attending Physician; The law requires that the death certificate be executed Exami After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Artorial Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 X No To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1145 93 Minale June 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doborah Pierce 25 MAIN STILLET REISTENSTOWN MD

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Alexander .

Registrar

JUN 2 7

COLLINS

State of the State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 20872 Reg. No. 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JUNE Day 26 -201218 12:05AM resie a 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Min Year) Davs Hours 1 □ M 2 🕱 F Yrs 212-26-6269 28 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Itamor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☑ Divorced Specify 3hit 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) esting ginee 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9239 Harford FIndrew Cie Tive. 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislaus
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2 4 ☐ Donation 5 ☐ Other (Specify) (0 22. Name and Address of Facility 21. Signature of Funeral Service Licensee apel & Cremation Services Funeral 8800 Harford Parkuil Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARRHYTHMIA disease or condition resulting in death) Due to (or as a consequence of): RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). END STAGE CHRONIC OBSTRUCTIVE Due to (or as a consequence of): PULMONARY DISEASE IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknowf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown INSUFFICIENCY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No autopsy

Physician /Medical Examiner

item 2

Department of Important: If it any Injury or o

Physician

/Medical

10a. State

Examiner

Funeral

Director

28a-f show

ò 23a

event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23.

Baltimore, Maryland 21215-0036

Funeral Director

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Completed

Be ၉

with the Maryland

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Act hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eathy filled in by the funeral director, page 2 should be detached for use as the burial-transit ≥ Completed Be 25. Was case referred to medical examiner? Certification: To 27. Manner of Death To the Hospital or within 24 hours at To the Funeral D

CRITICAL AORTIC VALVE STENOSIS RENAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes

2 **X**No

TOWSON, MARYLAND 21204

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

1 Yes 2 No

1 Natural
2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier M.

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 ☐ Pending investigation

6 □Could not be

determined

DØØ17695

completely

Medical

31. Date filed (Month, Day, Year) State JUN 2 Registrar

ABDALLAH

HELOU M. D. 32/Registrar's Signature

7601 OSLER DRIVE

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Cortificate of Death

Reg. No. 2008 20873 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25 3. Time of Death **Physician** Month WILLIAM R. CARTER JUNE 2008 4:05A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MASONIC HOME COCKEYSVILLE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 2,1922 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days XXM 2DF Mary Tand Director 218-14-2799 86 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 □ Yes 2√XNo Directo Marvland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 **USA** 300 International Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once. Black, White, etc. XXYes 2 No If Yes, Give WW 11 Year or Dates: 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 201X No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) Plant Management C.&P. Telephone Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Carter Jeanette Fairbank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13037 Beaver Dam Rd. Hunt Valley, Md. 21013 Lynn Bivona (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 3 ☐ Removal from State Metro Crematory, Inc. Baltimore, Md. 6-28-2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee L2a Strain Arter et Frity Home Lasse 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated based based based based and based should based should based should based 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 423 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1) 20649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

BOWIE,

JOHN W.

M.D.

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

6701 N. Charles St. Suite 4902 Towson, Md. 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** ANTHONY J. CACCHIONE 12:45P[™] 2008 /Medical JUNE 24 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OAKCREST VILLAGE N. H. BALTIMORE COUNTY BALTIMORE 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F Yrs. Director 135~07~0296 96 12,1912 Italy June Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8820 Walther Blvd. Apt. 209 21234 USA Funeral ould be filed within 72 hours after death Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2/CXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 ☐ No White ģ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CPA Accounting Firms vrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be If item 27 is marked or other traumatic ev Peter Cacchione Marie Antuzzi ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra William Rex Lenderman (PR) 606 Baltimore Avenue Suite 107 Towson, Md. 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 6-25-08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7401 Belair Rd. 6.3. Lassahn Funeral Home assala Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi Due to (or as a consequence of): Physician/Medical attending phase as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9∏ l Jnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nodule 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? 2 □ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA fter this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier

Division or Vital Records, P.O. Box 68760, ANTHONY

Baltimore, Maryland 21215-0036

within 24 hor To the Fune completely fi 10

State Registrar (Check only one)

29b. Signature and title of certifier

and manner stated.

monud

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Boulevourd

058646

29d. Date signed (Month, Day, Year)

Parleville

2005

08-04876 David Cabral Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 20875 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1823 hrs June 24, 2008 ' Examiner 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Essex 38 Seaford Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Country) **Funeral** Min Months Days Director 1 XM 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No or 28a-f show with the Maryland Director 10g. Citizen of What Country 10e. Street and Numbe 15A eni Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? Funeral 11 Marital Status White, etc must be death v Never Married 1 Yes ö Yes 2 No specify: If Yes, Give Year Divorced Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Widowed If item 27 is marked other than "natural", oher traumatic event, the Medical Examiner 16b. Kind of Business/Industry \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Name (First, Middle, Last Be 9b. Mailing Address Method of Disposition crematory or other place) 2 Cremation 3 Removal from State Burial Donation 5 Other Specify 21. Signature of Juneral Service Lice Approximate Interval ich as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s Between Onset and Physician failure. List only one cause on each line. Death tedica. a Atherosclerotic cardiovascular disease mmediate Cause (Final disease _aminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The lay requires that the death certificate be executed and AMENDED 23a,27,perME,G881 7/15/08 TT Physician/Medical X UNPENDED ysician a 23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy ned by the attending phys detached for use as the bi IF FEMALE: Day Year 3 Ectopic pregnancy Fetal death 23b. Was decedent pregnant in the Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown δ 24b. Were autopsy findings available Completed 24a Was an has been prior to completion of cause of autopsy death? performed 1 Yes 2 No certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be Nursing Home 5 Residence 6 Other: Scene Hospital: 1 DOA ER/Outpatient 3 Inpatient 2 this 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: Yes 2 No 1 X Natural Pending hours after death. Director: d in by the f 28f. Location (Street and Number or Rural Route Number, City Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be Suicide determined within 24 hours at To the Funeral I Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) **Medical** 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 25, 2008 O.C.M.E. lue U 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Day, Year) 82. Registrar's Signature Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 8 20876 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Year Celan 5 00 AM Dean JUNG ,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Baltimore City 6310 Danville Avenue Baltimore City

9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Þ⊠M 2□F Months Days Hours Min Director 63 218-42-1409 Usual Residence of Decedent 08/27/1944 the Maryland 10a, State 10c, City, Town or Location or items 23a or 28a-f show 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evet. For must be notified at once. Director 1 Yes 2 No MD Baltimore City Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6310 Danville Avenue 21224 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. 2 Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Private Investigation Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ George Celani Elvira Amrosa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Celani/Daughter 6310 Danville Avenue Baltimore, MD 21224

f Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jun 25 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Inc 2008
22. Name and Address of Facility Beltsville, Maryland 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland 21286 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cirrhosis -10 46 /Medical Due to (or as a consequence of): Examiner ~ 5-10 years patic encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

H. Franklin

31. Date filed (Month, Day, Year) JUN 2 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

82. Registrar's Signature

Herlong;

D0023650

4940 Eastern Que. , Baltimore, MD. 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9:59 AM **Physician** ampbe JUN 2008 hawn Hntonio /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 214-30-6843 3 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County Show ? Is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" ~ " any Injury or other traumatic event in the state of the s USA 705 Bel Avenue by Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) University of MD Elementary/Secondary (0-12) College (1-4 or 5+) Decurity 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Coleman oraine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) '705 Belnord Avenue Chevella Campbell Balto, MD, 21205

20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 07/01/08 Windsor Mill Maryland King Memoria | Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Phillip A. Weather ford Funeral Services P 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21213 Approximate Interval Between Immediate Cause (Final ARRRIT Physician CARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 17EART Congitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to Cards a nonsequence of physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical ate has been signed by the attending pl page 2 should be detached for use as it 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Tes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed certificate has 2 🗌 No 1 TYes 2 1 Tyes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 \square Inpatient 2X ER/Outpatient 3 □ DOA မ within 24 hours after death.

To the Funeral Director: After this openpletely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mallace 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 7

2008

ORIGINAL

32 Registrar's Signature

			For State of N State Registrar	laryland / Depai <i>Cert</i>	rtment of F tificate of t		ental Hygie _{Reg.}	ne 2008	20878
	Physicia		1. Decedent's Name (First, Middle, Last) LEO E •	DIETRICH		2	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number			Location of Death	,	4c. County of Death	000
	Funeral Director		213-30-5956 ¹ ∑ M 2□ F	Age (In vrs. last birthday)		-	3. Date of Birth (Month, Day, Ye 10 – 29 – 1		place (State or Foreign htry) YLAND
	aryland show	_	Usual Residence of Decedent	10c. City, Town or Loca		EDALE		1	0d. Inside City Limits 1 ☐ Yes 2 ▼No
	h the Marin 128a-f	Director	10e. Street and Number		10f. Zip Code	EDADE	10g.	. Citizen of What Cour	
	eath wit	Funeral D	1510 BRIAN ROAD 11 Marital Status 12. Was Deceder	at Ever in U.S. 13 W		237	ifv Yes or No-	U.S.A.	can Indian.
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination until but will added.	ρ	Armed Forces	¬No	Yes, specify Cuba	Ilspanic Origin? (Spec an, Mexican, Puerto Ri Specify:	ican, etc.)	Black, White,	
215-0	nin 72 ho e. In "natu Wedical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40	(Give ki	ent's Usual Occup ind of work done O NOT use retired	ation during most of working d)		b. Kind of Business/In	yntsuk
3212	lled with Hygiene ther tha nt, the		Elementary/Secondary (0-12) College (1-40 1 2 17. Father's Name (First, Middle, Last)	MACE	HINIST	18. Mother's Name (BETHLEHA	M STEEL
/land	uld be f Mental arked or	To Be	LEO LUKE DIETRICI	H		MARY	BARBAR		ER)
Mar	alth and 27 is mit and 27 is mit and 27 is mit ar trauma		19a. Informant's Name/Relationship (Type. Print) DOROTHY DIETRICH/WIFE		Address (Street BRIAN		Route Number, C. SEDALE ,	ity or Town, State, Zip MD 212	
nore,	ages 1 a ant of He t: If item y or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from Stat 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposi cemetery, creme HOLY HILI			1	c. Location - City or To	
Baltimore, Maryland 21215-0036	permit. P Departme Importan any Injur	j	21. Signature of Funeral Service Licensee	22.	Name and Addre		CH/ROSE		ERAL HOME 21237
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not enter					Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. // 12/57 Due to (or a	riTial Lung as a consequence of):	diseas	e, Respir	colory	Failure	
	Examiner	-i	Sequentially list conditions,	STOSIS					
K	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a condition)	as a consequence of):					
68760,1	ficate be executed physician and s the burial-transit	ledical E	d	to a consequence or,					
% 68	eath certific attending pl for use as t	//Med	IF FEMALE: 23c. If yes, outcom	ne of pregnancy				23d. Date of deliv	erv
.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	n 2 🗆 Fetal death 3 🗆 t at time of death 5 🗆	Ectopic pregnand Other (specify) _	у		Month	Day Year
ds, F	uires that the de signed by the a d be detached f	5	Part II. Other significant conditions contributing to death HyperTension	_	_	en in Part I.		cco use contribute to t	
ecor	e law requir has been si je 2 should b	Completed					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
a B	in: The ificate h or, page		25. Was case referred to medical			26. Place of Death	performed	d? death?	
Ž	ıysicia iis cerl directe	o Be	examiner?	atient 2 ER/Outpatient	3 □ DOA Oth	or:		ce 6 Other (Speci	fy)
o uo	ding Physician: The Ih. After this certificate har funeral director, page	tion: T	TEMARKIAN SELECTIONS	njury 28b. Time of Injury	28c. Injur Wor		8d. Describe how		
Division of Vital Records, P.O.	I or Attene after death Director: d in by the	Certification: To	3 Suicide 6 Could not be 28e. Place of I	Injury - At home, farm, stree etc. <i>(Specify)</i>			Bf. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	s of examination and/or inve	occurred at the ti estigation, in my	me, date and place, a ppinion, death occurre	nd due to the cau d at the time, date	se(s) and manner as a and place, and due t	stated. o the cause(s)
_	To the within To the comp	Me	29b. Signature and title of certifier		29c. Licens		29d	. Date signed (Month,	-
	. 1		1 Klymy	5 de-all (laser 00:) (T		+736		6-26-	- 2008
	lo		30. Name and address of person who completed cause of DR Kamuan R. Augieun G	9000 FRAI	nKLIN S	auare D	r Bal	To md a	21237
	Sta Registr	- 1	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	lis .				

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DIETRICH

State of Maryland / Department of Health and Mental Hygiene 20879 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 24, Physician 2008 9:30 AM Lana B. DeRosa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Rockville Hebrew Home of Greater Washington 8. Date of Birth (Month, Day, Yea Sept. 20, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 1918 Kentucky Sept. 89 Director 048-10-9593 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2K No must be notified Directo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö United States 20906 23a 15115 Interlachen Drive Funeral items 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " College (1-4or 5+) Elementary/Secondary (0-12) n and Mental Hygiene. Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lily Witt Wiley Holmes 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15115 Interlachen Dr., Silver Spring, MD 20906 Robert A. DeRosa / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 30, 2008 Silver Spring, Maryland Gate of Heaven Cemetery 21. Signature of Funeral Sery Robert A. Pumphrey Funeral Home/Rockville, Inc. 800 W. Montgomery Ave., Rockville, MD 20850-2805 M00896 23a. Part1. Ent. If the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 months Physician Frailty Syndrome /Medical Due to (or as a consequence of) **Examiner** Failure to Thrive months Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Alzheimer's Dementia attending physician and for use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnar 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 4□Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Left Femur Fracture 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has lirector, page 2 s 1□ Yes 2 X No or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☑ No 2 Accident June 23, 2008 10:35PM Fell on way to restroom Director; 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 6121~Montrose~Rd . 4 ☐ Homicide within 24 hours after

To the Funeral Dire

completely filled in by Hebrew Home of Greater Washington Rockville, Maryland 20852 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Unden June 25, 2008 D0036716 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundrat, M.D., 6121 Montrose Rd., Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 327 Registrar's Signature State 7 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 200820880 Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death Day 2008 Month **Physician** 25, Steve Dedianko June 2:10p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Timonium If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 196-09-5315 Director 92 July 15, 1915 Johnstown, PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the "motical Evanther must be notified at MD Baltimore Owings Mills Directo 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8130 Greenspring Valley Rd 21117 USA by Funeral within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: white 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Steelworker manufacturing permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic events 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Dedianko Juliyana Lisanico ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Patricia Dedianko - daughter</u> 8130 Greenspring Valley Rd, Owings Mills, MD 21117 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grandview Cem 6/30/08 <u>Johnstown, PA</u> Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the dise se. Ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lips Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ned by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐ No **Division of Vital** 1 ☐ Yes 2 X No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) HOSPICE 1∐Yes 2**X**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural ithin 24 hours after death.

the Funeral Director: A puppletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature tle of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

EDDIE NAKHUDA

31. Date filed (Month, Day,

JUN 2

2008

25,

STEVE DEDIANKO

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Ignature

			For State Registrar		ai yiai k		tificate of	Death		Reg. No.	2008	
	Physici	an	Decedent's Name (First, Middle, Last						2. Date of De Month	Day		3. Time of Death
-	/Medic		JOHN CHARL		NO	· ·			June		2008	2400 M
	Examir	ier	4a. Facility Name (If not institution, give					or Location of Deat	th		County of Death	
			HOSPICE OF BALTIM 5. Social Security Number 6. S			Γ CENTI	ER Tow If Under 1 Year		. 8 Date of Bir	<u>B</u>	altimor	e County
	Funeral Director			M 2□ F 7. Age	60	Yrs.	Months Days	Hours Min.				nplace (State of Foreign untry) ryland
	land w		10a. State 10b. County		10c. City	, Town or Loc	ation	·			T	10d. Inside City Limits
	Mary f sh	Ď,	Marvland N/	,		Balt	imore					1 X Yes 2 □ No
	the	iec	Maryland N/ 10e. Street and Number	A		Dait.	10f. Zip Code			10g. Citi	zen of What Cou	untry?
	3a ou	0	221 East Norther	n Parkway	Ant	G		21212			USA	
	death ms 2	Jer	11. Marital Status	12. Was Decedent 8				Hispanic Origin? (§ an, Mexican, Puer	Specify Yes or No	-	14. Race - Amer	rican Indian,
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evaninar nuet be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑Yes 2 ☐ N If Yes, Give Year or Dates:	19	67	Yes, specify Cub ☐Yes 2 No		to Hican, etc.)		Black, White	hite
5-(72 h 'natu	ete	15. Decedent's Ed (Specify only highest gra	ucation de completed)		(Give k	ent's Usual Occup aind of work done	during most of wo	rking	16b. Kii	nd of Business/I	ndustry
121	within lene. than "	ם	Elementary/Secondary (0-12)	College (1-4or 5	+)		O NOT use retire	d)		_		
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anc	be od o	å	17. Father's Name (First, Middle, Last)	D.1.5. 6					me (First, Middle,		,	
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Maryland	nd 2 sho alth and 27 is me r trauma		19a. Informant's Name/Relationship					and Number or R				
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Baltimore,	0 0		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	1)		y Rede	ition (Name of atory or other place emer Cen	netery 6/	′28/2008	Balt	timore,	Maryland
Bal	permit. Page Department Important; if any Injury o		21. Signature of Funeral Service Liver	son		M 6.5	Name and Addre ITCHELL- 500 York	wiess of Facility WIEDEFEL Road, B	D FUNERA altimore	L HO	ME, INC	21212
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death	. Do not ente	r the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition			GENI	c C1	RRHOS	18			Onset and Death
	/Medical		resulting in death)	Due to (or as					2			***************************************
	Examiner			h								
	p +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):						
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0,	e exe		resulting in death) Last	Due to (or as	a consequ	ence of):				-		
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	ng ph	Med	IF FEMALE:									
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۳,	that hed b deta		Part II. Other significant conditions c	ontributing to death bu	ut not resu	lting in the un	derlying cause giv	ven in Part I.	23e. Did t	obacco u	ise contribute to	the cause of death?
ds	uires n sign ld be	d by			_				1 🗆	Yes 2	XNo 3□ Pro	obably 4 Unknown
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Re	The law cate has page 2	п							auto		prior to death?	completion of cause of
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of	Phys er this eral di	: To	27. Manner of Death	28a. Date of Inju	ry	28b. Time of	28c. Inju		Home 5 Resi		Other (Spec	city) rocsy rec
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Division	al or / s after il Dire	Certification:	4 ☐ Homicide determined	building, etc	:.1(Specify	,)			City or To	wn, State,)	,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) Check only one)	ysician: To the best on niner: On the basis of and manner sta	f examinat	wledge, death ion and/or inv	occurred at the trestigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) date and) and manner as I place, and due	stated. to the cause(s)
	Voithin comp	Me	29b. Signature and title of certifier All and	3			29c. Licens	se number 8303		29d. Dat	te signed (Month	n, Day, Year)
L	1		30. Name and address of person who	completed cause of d	eath (Item	,23a) (Type, F	Print) Ch	8303 arl, 57	- Touso,	SI	10 Z1Z	4
	Sta		31. Date filed (Month, Day, Year) JUN 2 7 2008	.32. Registra								
	Registr	ar	0011 10 1 2001	39		-/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 25, 2008 8:19 June Elizabeth Viola Emmke /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2**X**) F 218-05-3371 91 June 23, 1917 Maryland Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Evan incr a ust be notified at MD Baltimore Towson 1 □Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 72 hours after death with 259 Linden Avenue 21286 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 0 Maryland 21215-0036 1 □Yes 2 🖔 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. At Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 nd 2 should be filed walth and Mental Hygier 27 is marked other the traumatic event, Its 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Nace Oliver Stephen Freeland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is: any injury or other traus Gloria J. Strack/Daughter 250 Ridge Avenue Towson, MD 21286 Baltimore, 20b. Place of Disposition (Name of Du Parely cramping of other place)
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06/28/08 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Eans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sinck, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death GERIATRIC YEARS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine certificate be executed and Due to (or as a consequence of): burial-Box 68760, attending physician Physician/Medical the as nse yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for (Month Day Pregnant at time of death 5 Other (specify) P.O. ned by the detached 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. δ Cerchroroscular No 3 Probably 4 Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Wispt W Hospital: 1 ☐ Yes 2/6 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Seath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

V

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

rachins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ature

June 26 2008

W. Charles St Powson us 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director				53	Yrs.	Months D	ays Hours	Min. (Mont	h, Day, Yea	1954 Pue	nplace (State or Foreign untry) erto Rico
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	ter de item iner r	'n.	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔼 N		, 10.			gin? (Specify Yes 1, Puerto Rican, etc	5.)	Black, White	
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g)	Heg Heg		20a. Method of Disposition		20b. Pl	ace of Disp	osition (Name o	of r place) T	une 20,	20c.	Location - City or	Town, State
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Baltimore,	permit. Pages Department of Important: If it any Injury or of once.		21. Signature of Funeral Service Licens	;ee		2	2.Name and A Kirkley 421 Cra	ddress of Facility -Ruddic	k Funera		P.A. Burnie, M	
	2 40 379		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death						,	Approximate Interval Between
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X	The law requires that the death certif ite has been signed by the attending page 2 should be detached for use a	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of del	ivery
. Box	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at 9□Unknown			□Ectopic pregi □ Other <i>(speci</i>				Month	Day Year
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S	es tha	by F	Part II. Other significant conditions of	intributing to death bu	ut not resu	Iting in the	underlying caus	e given in Part I	. 23e			the cause of death?
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ec	ne law has b ye 2 sh	Completed							24a.	Was an autopsy performed:	prior to o	itopsy findings available completion of cause of
<u>=</u>	r: The									Yes 2021		2 □ No
Vital	Physician: The la r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☐ No	Hospital:		TD/Outrotic	2U DOA	Othor	e of Death (Check	-	a Dou (a	· · ·
ō	Physic ruthis stal di	: To	27. Manner of Death	28a. Date of Inju	ry T	28b. Time		Injury at Work?			6 □Other (Spe- jury occurred	сіту)
Q	nding Ph th. :: After th e funeral	tion	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y Year)	Injury	M	Work? 1 Yes 2	No			
Division or	Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju	ury - At ho	me, farm, s	treet, factory, o	ffice	28f. Loca	tion (Street or Town, St	and Number or Ru	ural Route Number,
	tal or s afte al Dir ed in	Cert		Daniering, and	o. (Opcom)					0, 10,11,10,1		
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	(10)		30. Name and address of person who o	completed cause of d	eath (Item	23a) (Type	, Print)	n			, ,	
	\vee		31. Date filed (Month, Day, Year)	32 Banietr	ar's Signa	LASI	72 7.	, 151	MITIMA	₹ lir	2) 3/6	19
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Ĭ	Examin		4a. Facility Name (If not institution DOVE HOUSE HOST				4b. City, Town, o				- 1	County of Death	
-	Funeral		5. Social Security Number	1 - X 1 2		ast birthday)	If Under 1 Year Months Days	If Unde	r 24 Hrs. Min.	8. Date of Bir (Month, Da	th av. Year)	9. Birthp	place (State or Foreign
	Director		332-05-5032 Usual Residence of Decedent	9	3	Yrs.				NOV. 2			ILLINOIS
	yland now at		10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	ne Mar 8a-f sl ptified	ctor		RROLL	WE	ESTMIN							1 ☐ Yes 2 X No
	th with the 23a or 2	Funeral Director	10e. Street and Number 505 HIGH ACRE	DR			10f. Zip Code 211	57			10g. Citiz	en of What Cour A	ntry?
36	rs after dea I", or Items xaminer mu	by Funer	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Dyes 2 N If Yes, Give Year or Dates:			Was Decedent of I f Yes, specify Cub I ☐ Yes 21 No	Hispanic O ean, Mexica Specify	arī, Puerto	ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: WHI	etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5-	+)	(Give life. L	lent's Usual Occu kind of work done DO NOT use retire AM FITTE	during mo d)	st of worki	ing		nd of Business/Ind	dustry
	filed w Hygier ther th	So	12th 17. Father's Name (First, Middle,	Last)		OIL	Ari FILLI		ner's Name	(First, Middle			
Maryland	uld be idental rked o	To Be	ERNEST EGGERS	•						REDFEAR	,		
Mary	12 shoin and hand hand hand his ma	Ė	19a. Informant's Name/Relationship (Type. Print) ROGER EGGERS—SON 19b. Mailing Address (Street and Number or Rural Route Number, City of 3394 SCHAEFER DR HAMPSTEAD,										
	1 and Healt tem 27 other 1		20a. Method of Disposition	ON	20b. Pla	L ace of Dispo	sition (Name of	ī		Date		cation - City or To	
imo	Pages ment of I ant; If its ury or o'		1 ☐ Burial 2	3 ☐Removal from State pecify)			natory or other pla EMATORY	ce)	6/2	6/08	BAI	LTIMORE,	MD
Baltimore,	permit. Departi Imports any Inj		21. Signature of Funeral Service	Licensee	>		Name and Address		PILI			FUNERAL MD 21206	HOME, INC
			23a. Part1. Enter the disease, o shock, or heart failur.	omplications that caused only one cause on each lin	the death.	Do not ent	er the mode of dyi	ng, such a				21200	Approximate Interval Between
,	Physician / /Medical		Immediate Cause (First disease or condition resulting in death)				Dele	7					Onset and Death
	Examiner			Due to (or as a	a conseque	ence or):							
	sit sed	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a conseque	ence of):							
Ć,	execut n and ial-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a conseque	ence of):							
8760,	icate be executed physician and s the burial-transit	dical		d									
.O. Box 6	sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal o	death 3□	Ectopic pregnanc Other (specify)	у			2	3d. Date of delive	ery Day Year
<u>α</u>	luires that n signed by lld be deta	by	Part II. Other significant condition	ons conflicting to death bu	not result	ting in the ur	nderlying cause gi	ven in Part	l.	23e. Did 1			he cause of death?
l Records,	The law rec ate has beel page 2 shou	Completed	Bever	- Proof	di	Hy.	selve	n Co		24a. Was auto perfo	an psy prmed?	24b. Were auto prior to co death? 1 □ Yes	opsy findings available mpletion of cause of 2□ No
Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		//	low		e of Death	(Check only			
0	Attending Physician: The r death. ector: After this certificate h. by the funeral director, page	1: To	1 Yes 2 No 27. Manuar of Death	28a. Date of Injur	y 2	R/Outpatien 28b. Time of	1 3 DOA			me 5 Resi		Other (Specif	(y)
ion	arth. pr. Afte	atior	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	Year)	Injury		rk? ∣Yes 2∐]No				
Division or	Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	ertification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ry - At hon :. (Specify)	ne, farm, str	eet, factory, office		1	28f. Location (City or To	Street and wn, State)	l Number or Rura	al Route Number,
	I 4 I 0	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical I	g Physician: To the best of Examiner: On the basis of and manner sta	examination	rledge, death on and/or in	n occurred at the t vestigation, in my	ime, date a opinion, de	and place, eath occurr	and due to the red at the time	cause(s) , date and	and manner as s place, and due to	tated. o the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier				29c. Licens	se number			29d. Date	signed (Month,	Day, Year)
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Laura Kristen Go		G S - For State	state of Maryl	and / Depar Cert	ificate	of Death	iu ivierii		Reg. No	20	08 208	8
Physicia		egistrar 1. Decedent's Name (First, Mid	dle,Last)				III	2. Date of Do		Year	3. Time of Death	7
Mr ¬I Examin	er	Lau			Goddard			June 25	, 2008	c. County of Deat	0142 hrs	4
ì		 Facility Name (if not institut 1320 Martin Blvd. 	tion, give street and n	umber)		4b. City, Town, o	r Location of			Baltimore Co	unty	
Funeral	7	5. Social Security Number	6. Sex	7. Age (In yrs. Ia	st birthday)				Birth (MM	I Forei	rthplace (State or	٦
Director	*	218-98-7584	1 M 2 X F	32		Yrs. Months Da	ys Hours	Min. Oct.	9,	1975 ^c	ountry) Maryland	\sqcup
any		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City,	Town or Lo	cation					10d. Inside City Limits	- 1
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with the Maryland ms 23a or 28a-f show be notified at once.	rect	10e. Street and Number	E E			10f. Zip Code	-0.0		10g. Ci	tizen of What Co		١
th the		4220 Mispill		ecedent Ever in U.S	3 113		236 Jispanic Orig	in? (Specify Yes or	No-		rican Indian, Black,	\dashv
ath wi	Funeral Director	11. Marital Status 1 X Never Married 2		Forces?	10.	If Yes, specify Cub	an, Mexican,	Puerto Rican, etc.)		White, etc.		
after de	by Ft		Divorced If Yes, Give Y	ear	4 '	Yes 2 X N			1.0		/hite	_
hours : natur	ed b	15. Decedent's Education (Sp.		ade completed) (1-4 or 5+)	16a. Dece durin	dent's Usual Occup g most of working li	ation (Give k fe. DO NOT	kind of work done use retired)	166	. Kind of Business	s/industry	
36 hin 72 e. than "	ompleted	Elementary/Secondary (0-12	2) College	(140/5/)	Pha	rmacy .	Techni	cian	P	harmacy		
5-00 ed with tygien other the M	S	17. Father's Name (First, Midd	lle, Last)				18.Mother	's Name (First, Midd			11	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Danie 19a. Informant's Name/Relatio		Godda	rd	iling Address (Str	eet and Num	Katheri nber or Rural Route	ne Number,	B. City or Town, Sta	Wagner Ite, Zip Code)	
MD 2 d 2 should the and M m 27 is m aumatic	٩	Katherine B.		Mother							/land 21236	3
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner.		20a. Method of Disposition			Place of Dis	position (Name of or other place)	cemetery,	Date	200	c. Location - City	or Town, State	
imor Pages ment of tant: Il		4 Donation 5 XOther	Specify Entomb		uid Ri	dge Ceme	tery_	7-1-2008			le Maryland	1_
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tilnjury or other traumatic event, the Med		21. Sig about runeral Serv			2	2. Name and Address 1050 Yor			son . Ma	Funeral ryland 2	Home, Inc. 21204	
°hysician		23a. Part I. Enter the disease, failure. List only one cau	or complications tha	t caused the death	. Do not en	ter the mode of dyir	ng, such as c				Approximate Interv Between Onset an	
Wedical _xaminer	4 3	Immediate Cause (Final disea	ase a. Coca	ine use							Death	
		or condition resulting in death	Due to (or a	s a consequence o	f):							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau		s a consequence o	f):							
179. E . II	Examiner	(Disease or injury that initiate events resulting in death) Lat	Due to (es e	s a consequence o	f):							
	_	X UNPENDED	d	_D #23a,27	,perM	E,g881 7	/25/08	TT				
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Box 68760, e death certificate by the attending physic ed for use as the but	ian/I	23b. Was decedent pregnant i past 12 months?		e birth egnant at time of de	2 eath 5	Fetal death Other (Specify)	3Ectopi	ic pregnancy	- 1	Month	Day Year	
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cal Records, P.O. Box 68760, cian: The law requires that the death certificate be execut certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - tra	by Pr	Part II. Other significant cor	nditions contributin	g to death but not i	esulting in	the underlying caus	se given in P	art I. 23e. [_		to the cause of death? Probably 4 Unknow	n
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Cord law red has be	Completed	·							autopsy performe (es 2	d? death		л
Rec		25. Was case referred to med	dical			26.P	ace of Death	(Check only one)	res 2	NO I V	Tes 2 110	_
Vital hysician this cert	o Be	examiner?	Hospital: 1	Inpatient 2	ER/Outpa	atient 3 DOA	Other ₄	Nursing Home		sidence 6 🗸 O	ther: Scene	
ision of Vital Rec Attending Physician: The L r deat. rector: After this certificate I by the funeral director, page	n: To	27. Manner of Death		ate of Injury onth, Day,Year)	28b. Tim	* '	Injury at Wor	_	ribe how	injury occurred		
Sion Attendi death. ctor:	satio		Pending nvestigation	Place of Injury At I	nome farm	street, factory, offi			ion (Stre	et and Number o	Rural Route Number, C	City
Division of Vital Records, rat or Attending Physician: The law requirers after death. The Invector that this certificate has been sided in by the funeral director, page 2 should be in by the funeral director, page 2 should be a shoul	Certification:		Could not be determined (Spec		iomo, raim	3.000, 1001017, 0			wn, State			
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To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical 29b. Signature and title of ce	and mann	er stated.	and or mye		ense numbe				(Month, Day, Year)	_
	_	dell	Brawl	IM	>	0	.C.M.E.			June 25, 2008	3	
d		30. Name and address of per	rson who completed	cause of death (Ite	m 23a)	44 D 21	4 Dal#	ro MD 04004				
¥		Melissa Brassell, N	ID Assistant	Medical Exam	iner 1	11 Penn Stree	ı, balumo	71 C, IVID 2 120 I				

State 31. Date filed (Month, Day, Year)
Registrar JUN 2 7 2008 DHMH 17 Rev 1/2001 OCME 2006

32. Registrar's Signature

OCME

State Registrar

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Maryland	
Baltimore,	
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			For State Registrar		State of Ma	arylan	d / Depa <i>Cei</i>	artment of r <i>tificate of</i>	Health a <i>Death</i>	and Me	ental Hyg	giene Reg. No. (2008	8 2	0887	
				e (First, Middle, La	st)					2	. Date of Dea	ath	Year	3. T	ime of Death	
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- Jan			Union M	emorial H	ospital				Balt	imore						
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	Director		242-36-4	4958	2	79	Yrs.	monale ally	110010			8/19				
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	arylan show	5	Toa. State												Sex es 2 □ No	
	the IV	Director	MD 10e. Street and Nu		ore City	Ba	ltimor	10f. Zip Code				10a Citiz	en of What C	Country?		
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21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it. M. dice. Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2 ☐ Married	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Decedent of If Yes, specify Cul I □Yes 2 ♣6			can, etc.)		Black, Wh Specify:		ical I _j	
ŏ	2 hot	b ed		15. Decedent's Ed	lucation		16a. Dece	dent's Usual Occu	pation			16b. Kin	nd of Busines			
715	in 72	Completed by	(Spec	cify only highest gra	de completed) College (1-4or 5	. \	(Give life. I	kind of work done DO NOT use retire	during mosi ed)	t of working	1	Own	Home			
212	y with	ē	12	midaly (0°12)	College (1-401 3	Τ)	Home	maker								
	othe othe	BeC		(First, Middle, Last)	1				18. Mothe	er's Name (First, Middle,	Maiden S	Surname)			
Maryland	uld be Jenta rked ric ev	TO B	Bennie	Young Stee	∍le				Jea	n Cam	pbell					
ary	shou and N		19a. Informant's N	ame/Relationship (Type. Print)		19b. Mailir	ng Address (Stree	t and Numbe	ber or Rural Route Number, City			ty or Town, State, Zip Code)			
Ξ	alth a		Mark Gat	tlin/Son			416	S. Ann	Street	Balt	imore,	MD	21231			
<u>re</u>	is 1 a		20a. Method of Dis			20b. P	lace of Dispo	sition (Name of natory or other pla	ace)	Dat		20c. Loc	cation - City o	or Town, St	ate	
E	Page nent c nt: If			Cremation 3 L 5 ☐ Other (Specif	Removal from State			ake_Crema	i		Jun 27	Bel	tsville	e. Mar	vland	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.			uneral Service Licer	· _	144	2 22	R. Name and Addr Cremation	ess of Facilit	у						
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σ.	that hed by deta		Part II. Other signi	ficant conditions o	ontributing to death bu	ıt not resu	ulting in the u	nderlying cause gi	iven in Part I.		23e. Did to	obacco us	se contribute	to the cau	se of death?	
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of	Phy: rthis raldi	 7	1 ☐ Yes 2 ☐ 27. Manner of Deat	-	28a. Date of Inju		ER/Outpatier 28b. Time of	I 3 LI DUA	4 🗆 NU		e 5 ∐ Resid d. Describe l		Other (Sp	oecify)		
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Division	or A after Dire	erti	4 Homicide	determined	building, etc	. (Specify	y)	,,,			City or Tov	vn, State)			-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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	To the Hos within 24 h To the Fun completely	Medical	one) 29b. Signature and	title of certifier	and manner sta	uea.		29c Licen	se number			29d Date	e signed (Mo	nth. Day V	/ear)	
	\ 5.≱5.8		250. Signature and	and or optimier				CO. LIGHT	0				- 0.91104 (1110)	, 2019, 1	/	
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	3		30. Name and add	ress of person who	completed cause of d			Print)	4	A //		(1	\	1	K1 ==	
			31. Date filed (Mon	Menu 9	NwaCh 32 Begistra	r's Signer	ner	- Un	lion	14/6	mon	a1 4	Hospi	italy	いしか.	
	Sta Registr		J. Date filed (Mon	UN 2 7 20	08 32. Registra	o Solgila	AJOR	vil								

08-04849 Phillip Gaddy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

llip G	Saddy		State of Maryland / Department of Health - For State Certificate of Death	and Mental Hygie	Reg. No.	20	
47	Physicia	n/	1. Decedent's Name (First, Middle,Last) Phillip Gaddy	M	ate of Death bonth Day Ine 24, 2008	Year	3. Time of Death 0234 hrs
-	'Examin		4a. Facility Name (if not institution, give street and number) 4b. City, To	wn, or Location of Death		c. County of Death	
		4	Good Samaritan Hospital 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	1	Date of Birth (MM	/DD/YYYY) 9. Birti	nplace (State or Foreign
	Funeral Director		5. Social Security Number 220-90-6463 6. Sex 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 2. Age (In yrs. last birthday) 2. Age (In yrs. last birthday) 2. Age (In yrs. last birthday) 4. Age (In yrs. l	Days Hours Min.	9-15-1	COL	MD
	ý.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	nd show any ice.		MD N/A Baltimore				1 XYes 2 No
	be filed within 72 hours after death with the Maryland antal Hygiene. rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.	Director	10e. Street and Number 3040 Mayfield Avenue	21213		tizen of What Cour USA	ntry ?
	h with th	L	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent If Yes, specify	t of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rica	y Yes or No- an, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
	ter deatl ", or ite er must		3 Widowed 4 Divorced If Yes 2 No 1 Yes 2	No specify:		орозну.	ack
	ours af	ed by	during most of work	Occupation (Give kind of work king life. DO NOT use retired)		Kind of Business/	ndustry
36	led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) 12th grade N/A Stock			Sorsira	
21215-0036	Hygier d other		17. Father's Name (First, Middle, Last)	18.Mother's Name (Fir			
	ould be fill Mental I marked ic event,	To Be	isa. Illionialico / talles	Rarbara (Street and Number or Rura			
Q N	and 2 should lealth and Me tem 27 is ma traumatic ev		20a Method of Disposition 20b. Place of Disposition (Nam	yfield Aven	ue Ba	Lto, MD c. Location - City o	Town, State
altimore	ages 1 a nt of He nt: If it		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	netery 7-1-	2008	Lansdow	n, MD
alfin	permit. Pages I and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Me		21. Signature of Funeral Service Licensee		arch Ea		MD 21202
ď	hysician		23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of	E. North Av of dying, such as cardiac or re	espiratory arrest, s	shock, or heart	Approximate Interval Between Onset and
	_xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot to Chest				Death
•			or condition resulting in death) Due to (or as a consequence of): Seguentially list conditions, b.				1
		miner	if any, leading to immediate cause. Enter Underlying Cause				
1	cecuted n and - transit	Exa	events resulting in death) Last Due to (or as a consequence or).				
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03603	orou, tificate bung physic as the bung	In/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnanc		Month	Day Year
;	box oor or he death certificate the attending phy: hed for use as the b	Physician/N	past 12 monuns? 4 Pregnant at time of death 5 Other (Special Yes 2 No 9 Unknown 9 Unknown	ecify)			C to all O
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	To the Hospital within 24 hours a To the Funeral	Medical		ne time, date and place, and on my opinion, death occurred at	the time, date an	u piace, and doe to	7 (1)0 24421(1)
	To To	Mag	and manner stated. 29b. Signature and title of certifier	9c. License number		29d. Date signed (June 24, 2008	Month, Day, Year)
	1.		Car of Hallar	O.C.M.E.			
	M		Odi of Alliant, III.2	, Baltimore, MD 21201	1 		
		Stat	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. /27/08 VS peni of Health and Mental Hygiene Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 10:20 PM 23 CATHORINE 2008 4012mm シントルモ /Medical 4a. Facility Name (If not institution, give screet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hillhaven Nursing Center Adelphi Prince George's If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days Min. Months Hours 1 M 2 XF 88 156-28-6451 Yrs DE Director 4/21/1920 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Mercerville Howard Mercer 1 🔁 es 2 No Director M 10e. Street and Number 67 McAdoo Avenue 6412 Autumn Sky Way 10g. Citizen of What Country? 10f. Zip Code USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. and 2 should be filed within 72 hours after eath and Mental Hygiene.

n 27 is marked other than "natural", or ite 18 Yes 2 No 1946 If Yes, Give Year or Dates: 1942–1945 1 Never Married 2 Married altimore. Maryland 21215-0036 White 1 ☐ Yes 2 🗷 No Specify 2 Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Registered Nurse Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Cabrey Margaret Mullarkey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health at Important: If Item 27 is any injury or other trau 6412 Autumn Sky Way, Columbia, MD 21044 Charles M. Gorman / son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State **™**Burial 2 □ Cremation 3 ■ Removal from State St. Mary's Cemetery 6/28/2008 4 ☐ Donation 5 ☐ Other (Specify) Hamilton, NJ 21. Signature of Foreral Service Licensee Dorota Marshall 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East fort Avenue, Baltimore, MD 21230 , W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FAMURE disease or condition resulting in death) 70 THRIVE /Medical Due to (or as a consequence of): Examiner ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or Examiner Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes O STEOPOROSIS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an DISEASE autopsy performed? Yes 25 No 25. Was base referred to medical examiner? 1∏ Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 70 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation To the Hospital or Attending 1 Natural Injury 1 □ Yes 2 □ No death. 2 Accident Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) 40 D55550 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) for the format STATES DR THOMAS HALLE . 7252 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008 7

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		For State Registrar		State of M	arylan		artment of F <i>rtificate of</i>	lealth and M	- `	0.1	0.00	00000	
		Registrar 1. Decedent's Name	e (First, Middle, La	ast)					2. Date of Dea	Reg. No	JUB	3. Time of Death	
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ould b Ments arked atic e	2	WILLIAM	T. SUI	LLIVAN					1C CULI				
2 sho		19a. Informant's Na					-	and Number or Rur) Code)	
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nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan arment of Heatly and Mental Hygiene. arment of Heatly and Mental Hygiene. Injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at e.		1 Burial 2		Removal from State	/	-	matory` or other pla CEMETE		2,200		•	•	
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To the H within 24 To the F complete	Medi	one) 29b. Signature and		and manner st	ated.		29c. Licens				igned (Month,		
T wit	-		amallè	Rai I M	D		RES				1E 25	2008	
0		30. Name and addr	ess of person who	completed cause of c	death (Item	1 23a) (Type.	Print)	2 2.026	A1A C		LIKA J	ITZA	
4		3001	SOUTH HI	completed cause of c	REET	BAI	TIMORE,	MD 21225	IVA U	MICAL	-100 41	· 1 + 1	
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Physicia	an	Decedent's Name (First, Middle, Last)			2. Date of De Month	Day Year	3. Time of Death		
/Medic	al	James A. Hooper Jr 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	JUI	VE 13, 20	08 03:57A		
Examin	er	Saint Joseph Medica		4b. City, Town, or Location	Towson		ltimore		
uneral irector		214-03-5880 ¹ \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Age (In yrs. last birthday 97 Yrs.	Months Days Hours	er 24 Hrs. 8. Date of Bir Min. (Month, Da May 10	th ly, Year) 9. Bi O , 1911 Mai	rthplace (State or Foreig Country) ryland		
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r 28a	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	Country?		
23a o	al D	13801 York Road Hallowel	.1 210	2103	80	USA			
Department or result and wenter righter. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ If Yes, Give	3?]No	. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐Yes 2 ☑ No Specif	an, Puerto Rican, etc.)	Black, Whi			
ural	ed by	3 Widowed 4 Divorced Year or Dates	44-46	**	,				
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arkec atic e	ဥ	James Albert Hooper		1	Martha Virgi	nia Pruett			
raum raum		19a. Informant's Name/Relationship (Type. Print)		ling Address (Street and Num			•		
em 27		Edythe Hooper/spouse 20a. Method of Disposition		01 York Road I	Date Date	20c. Location - City o			
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21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan tt of Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during modified DO NOT use retired)					most of working			Kind of Business/Industry		
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Baltimore, I	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		20a. Method of Disposition 1 → Burial 2 ☐ Cremation	3 □Removal from Sta	ate C	lace of Dispo emetery, cre	osition (Name of matory or other pla	ice)		ate	20c. Loc	ation - City or i	Town, State
Balti	permit. Departm Importal any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility							Arshall's Funeral . Washington, D.C			ome
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	To t To t	Ž	29b. Signature and title of certifier	24	~		29c. Licen	se numbe -4155				signed (Montl	
	7		30. Name and address of person of RUSSELL R. MOO.		of death (Item			NAT	CIONAL	NAVAL MD 20	MEDI	CAL CEN	
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 7 20	₫2 Rec	gistrar's Signa	ture	tes.	DEI	THEODA	PID ZU	,009-0	000	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 2008 June 26, 9:30 A. M Bryan Bedout Haddaway 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Gilchrist Hospice Center Towson 8. Date of Birth (Month, Day, Year) Oct. 27, 1927 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) BOS toll, Mass. 5. Social Security Number 7. Age (In vrs. last birthday) Sex 11 M 2 ☐ F Months Days Hours 08 223-32-9334 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 21 No Haryland Lutherville Baltimore County 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 8415 Tally Ho Road 21093 United States 12. Was Decedent Ever in U.S. Armed Forces? ¼ Yes 2 □ No If Yes, Give Year or Dates: W • W • II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2∑No White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Attorney Family Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Klein Kinzer Haddaway Miriam Bryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Ann Carole Haddaway (Wife) 8415 Tally Ho Road Lutherville, MD. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) June 27 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 24 Cremation 3 ☐ Removal from State Evans Funeral Chapel 2008 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licenses Port Enter the liseas of short, or heart ailur Li compliment his that can sed the death, only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 0 XICI veeks disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events em resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy
performed2

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS Pice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation in advertent ingestion 1 Natural UNKNOWAM 1 ☐ Yes 2 🗹 No June 5, 2008 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 8415 Tally ho Rond, Lothers We nd Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

/Medical Examiner o Records, Vital Division of

HADDAWAY

attending philor use as the signed be page 2 Physician: director, this funeral or Attending hours after death. uneral Director: Af ely filled in by the fur n 24 hou. **الe Funeral Dir.** الا filled in bv Hospital

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Physician/Medical Examiner

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(Check only one)

29a. Certifier

Funeral

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Pages 1 and 2

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29b. Signature and title of certifier

7 2008

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29c. License number

f 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) June 26, 2008

30. Name and address of person who completed caus of eath (Item 23a) (Type, Print) BINC

Itome

6701 32 Registrar's Signature

. Charles St. Balto, and 71203

31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 20894 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 3:45 AM 2008 Looper June 26 Ilian /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3901 Darleigh If Under 1 Year if Under 24 Hrs.
Months Days Hours Min. altimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 ☐ F Yrs. 213-28-2472 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "nature!", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Ithmore ottinahan 10e. Street and Number 10f. Zip Gode 10g. Citizen of What Country? 31 212 3901 Koac 0 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 📉 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: δ 3 ☐Widowed 4 ☐Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) omemaker 12 nwc 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 end 2 should be fit tment of Heelth and Mental H tant: If item 27 te marked otl eresa Joseph ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DD0053901 Hingham MD 21236 Villiam 20a. Method of Disposition 20b. Place of Disposition (Name of Date 2 - Location - City or Town, State cemetery, crematory or other place) 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Memorial Gardens slaney v Department of Important: If eny injury or once. 6-30-08 Timonium 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Chapel + Cremation Rd Parkville M Services Evans Funeral Chap 8800 Harford Rd MD 21234 acu Approximate Interval Betweer Opent and Deatl 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician /Medical Astic Syndname 4 Due to (or as a o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cons Examiner physiclen end s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mop Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No ivision of Vital Records, P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use constitute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 1100 3 Probably 4 Unknown 1 TYes 24a. Was an autopsy performs Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) certificate has birector, page 2 s 1 Yes 2 No : After this certifical funeral director, f 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Medicai Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide ō 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) o the 29b. Signature and, tle of 29d. Date soned (Month, Vay, Year) 29c. License number

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Registrar

30. Name and address of person

Cay, Year)

JUN 2 7

31. Date filed (Month,

BlerDrive

lowson MD 21204

completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Marylan		artment of F ctificate of a				008	20895
		1. Decedent's Name (First, Middle, Last)					2. Date of Death		V	3. Time of Death
Physic /Medi		Raymond Anthony	Huber, Sr.				Month June	Day 24		8:55 PM
Exami		4a. Facility Name (If not institution, give			4b. City, Town, o	Location of Death		T		
		Gilchrist			Towson			В	ay Year 2008 2089 ay Year 2008 8:55 P c. County of Death Baltimore 9. Birthplace (State or Fore Country) Maryland 10d. Inside City Lin 1 Yes 2 Interval Black, White, etc. Specify: White (State of Business/Industry) tate of Maryland (State of Business/Industry) tate of Maryland (State of Business/Industry) tate of Maryland (State of Business/Industry) tate of Maryland (State of Business/Industry) tate of Maryland (State of Business/Industry) tate of Maryland (State of Business/Industry) tate of Maryland (State of Business/Industry) tate of Maryland (State of Business/Industry) tate of Maryland (State of Business/Industry) tate of Maryland (State of Business/Industry) tate of Maryland (State of Business/Industry) Town, State, Zip Code) 21234 Cocation - City or Town, State Simonium, Maryland (State of Business/Industry) Approximate Interval Between Onset and Death (State of Business/Industry) Town (State of Business/Industry) 23d. Date of delivery Month Day Year use contribute to the cause of death? 2 No 3 Probably 4 Unknown (State of Business/Industry) 24b. Were autopsy findings availate prior to completion of cause death? 1 Yes 2 No 6 Nother (Specify) Hospical (State or Fore Country) and Number or Rural Route Number, (e)	ore
Funeral	П	5. Social Security Number 6. Sex		ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birthp	lace (State or Foreign
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or 24	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of \	What Coun	try?
th w	Funeral Director	8340 Kendale Roa	d		21234	+		U.S./	. F	
ems ems	ne	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?		Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)			
or affe	by Fi	1 Never Married 2 Married	1 ⊠Yes 2 ☐ No If Yes, Give		□Yes 2⊠No	Specify:	, ,			
5-UUSO 72 hours aft natural", or	q p	3 Widowed 4 Divorced	Year or Dates:						wn	
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or of series		20a. Method of Disposition 1 ☒ Burlal 2 ☐ Cremation 3 ☐ R	Companyal from State	emetery, crem	natory or other plac	e) !			•	
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DESILITIOTE, INIGITY ISING Z I Z I 3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. If will be trained must be notified at once.		21. Signature Puneral Service License		22	. Name and Addre	R	uck Tows	on Fune	eral H	Home, Inc.
		xallala,	sudu)			ck Road,	lowson, M	Marylar	nd 21	1204
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death ne cause on each line.	. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,		Interval Between
Physician	8	Immediate Cause (Final disease or condition	. Pulmon Due to (or as a consequ	ARH	HUPER	TENSION	1		_ 1	
/Medical		resulting in death)	Due to (or as a consequ	ence of.	1					777
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and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								,
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ath cer ttendir or use	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	у				
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g Ph er th	i i	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur Worl		28d. Describe ho			71103150
e fer Africa	ati	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury		Yes 2 □ No				
Atte Atte ecto by th	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho	me, farm, stre	eet, factory, office		28f. Location (Str	eet and Numb	er or Rura	l Route Number,
d in the second	Cert	4 🗆 Hornicide	building, etc. (Specify)			City or Town	, State)		10
spita hours inera y fille		29a. Certifier 1 Certifying Phys	sician: To the best of my know	wledge, death	occurred at the til	me, date and place,	and due to the ca	ause(s) and m	anner as s	tated.
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Examinations)	ner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my o	pinion, death occur	red at the time, da	ate and place,	and due to	the cause(s)
To the within To the Comp.	ž	29b. Signature and title of certifier	2020		29c. Licens	e number	29	d. Date signe	d (Month,	Day, Year)
		101	/////	7	26	4395		JUNE	25	,2008
11/		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type. F	Print)					
lor,		DANIEUE DOBERMI	AN, MO 6565	NCHA	PRUS ST	SUITE20	9 BAL	TIMORE	MD.	21204
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	20					
* Registr		JUN 2 7 ZUUS	B 48 48 45 B	A. 100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

20896 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 26 2008 **Physician** 11:15 AM June Hayden Audrey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Pasadena Anne Arundel 8412 Lockwood Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Sept. 04 1927 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days 262-32-9728 Sept. Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8412 Lockwood Road 21122 IISA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Baltimore, Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hairdressing Hairdresser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Mvers John Giddings Sidnev မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8412 Lockwood Road, Pasadena, MD 21122 (spouse) Roland W. Hayden 20c. Location - City or Town, State June 30 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Glen Burnie, Maryland Glen Haven Cemetery 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service Licensee 3111 Mountain Road, Pasadena, MD 21122 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Immediate Cause (Final disease or condition resulting in death) Physician nonea /Medical Due to for w a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or neighbor Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician the ! use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? certificate has been signed l ector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ Ho 24a. Was an autopsy performe 2 1 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 ☐ Nursing Home 5 ☐ Besidence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation s after decral Director: Aftr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours af

To the Funeral D

completely filled i 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier who completed cause of death (Hem 23a) (Type, Print) 30. Name and address of person 10 Registral's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 20897 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Hall 4:45 A M Kathryn JUNE 24 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Chesapeake Anne Arundel Arnold If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Funeral Months 1 □ M 2 1 F 171-40-1901 59 08-15-1948 Director PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant of Health and marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Vista Avenue 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21X No white Specify: Specify. Completed by 3 ☐ Widowed 4 2 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Teaching 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Clarence Lechner Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once, MRs. Debra Ray / friend 212 Foxtree Drive; Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ICremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Speelly) Chesapeake Cremation 6-26-2008 Stevensville, MD 21. Signature of June ral Service Live 22. Name and Address of Facility Singleton Funeral & Cremation 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YSTIC disease or condition resulting in death) ADENOCARCINOMA OF PANCREAS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or as a consequence of) attending physician and for use as the burial-tran Physician: The law requires that the death certificate be exect Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached it 1☐ Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy perform certificate 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director; the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

10 State Registrar

DHMH 17 Rev 1/2001

ball

8601 Veterany Hwy Suit 204 Millersville, MD 21108

mis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

mobit Nex

Physician

/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CARROLL CARROLL HOSPITAL CENTER WESTMINSTER If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Min. 1 □ M 2 2 F 217-12-2745 84 Director 3/22/1924 PENNSYLVANIA Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County HAMPSTEAD MD CARROLL Director with the 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 'natural", or items 23a or 1142 SOUTH MAIN ST. 21074 USA death v the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: WHITE ģ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANAGER SENIOR CENTER 12 s 1 and 2 should be filed w f Health and Mental Hygier ttem 27 Is marked other tt permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be COOL **AMBROSE** RUTH GEARHEART 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 1 0 2 19a. Informant's Name/Relationship (Type. Print) SUSAN SPIVEY - DAUGHTER 3000 MANCHESTER RD., APT. 2, MANCHESTER, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/25/08 | HAMPSTEAD, MD WESLEY CEMETERY 21. Sin atua of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 Ε. MAIN ST., WESTMINSTER, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of): Box 68760, nding physician certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery death o 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 2 No 3 Probably 4 donknown 1 ☐ Yes been si should I 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has certificate 1∐ Yes 2 NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number (3970) \(\text{\text{\$M\$}} \) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier person who completed pause of death (Item 23a) (Type, Print) East Main St Westminster MD 245 Hosain MU 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State
Registrar Amend 2, perMD, 9880 6/27/08 TT

1. Decedent's Name (First, Middle, Last)

CLARA ELIZABETH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

HAGAN.

Certificate of Death

Reg. No. 2008

20

Day 2008/ear,

-10 P M

Birthplace (State or Foreign Country)

10d. Inside City Limits

21157

Year

Day

1 XYes 2 □ No

2. Date of Death

Month

DHMH 17 Rev 1/2001

ORIGINAL

	1 _ State	epartment of Health and Certificate of Death	Mental Hygiene Reg. No 2008 20899
	Registrar 1. Decedent's Name (First, Middle, Last)	Detinoate of Boath	2. Date of Death 3. Time of Death
Physician	Gloria J. Haggerty		June 25 2008 2:20 A M
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	
	1606 Forbes Street	Rockville	Montgomery
Funeral Director	5. Social Security Number 6. Sex 1 □ M 2 🖾 F 7. Age (In yrs. last birth 4. Security Number 216-82-6677	day) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 16, 1921 9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent		Sept. 10, 1921 Tennsylvania
nylan how Lat	10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
vith the Mar r or 28a-f sl be notified	Maryland Montgomery Rock	ville	1ሺYes 2□No
or 2	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
s 23a	1606 Forbes Street	20851	United States ipecify Yes or No- 14. Race - American Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy highly or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Never Married 2 ☒ Married	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.) 14. Race - Affendan Indian, Black, White, etc.
ours a nual; o	If Yes, Give Year or Dates:	1 ☐ Yes 2 I Z No <i>Specify:</i>	Specify: White
ed within 72 hor ygiene. her than "natura t, the Medical E	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of wo life. DO NOT use retired)	16b. Kind of Business/Industry
withir than the Me	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	Own Home
Hygi Hygi Sther ent, t	17. Father's Name (First, Middle, Last)		me (First, Middle, Maiden Surname)
Mental be Mental arked c	John Greco	Rose	Colosimo
shot sand h	19a. Informant's Name/Relationship (Type. Print) 19b.	Mailing Address (Street and Number or R	ural Route Number, City or Town, State, Zip Code)
and 2 and 2			Bethesda, Maryland 20816
of High Paragraph of the control of	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Disposition (Name of crematory or other place)	Date 20c. Location - City or Town, State
Fag tment tant:	4 □ Donation 5 □ Other (Specify) St. Mar		28, 2008 Rockville, Maryland
permit Depar Impor any In	21. Signature of Funeral Service Licensee M00896	22. Name and Address of Facility Robert A. Pumphrey 300 W. Montgomery	Funeral Home /Rockville, Inc. Ave. Rockville, MD 20850-2805
STIES.	23a. Part1. Enter the disc ase, or complications that caused the death. Do no shock, or hear fail-re. List only one cause on each line.		c or respiratory arrest, Approximate Interval Between
Physician	Immediate Cause (Final disease or condition Alzheimers Der		Onset and Death
/Medical Examiner	resulting in death) Due to (or as a consequence of):	
	Sequentially list conditions, if any, leading to immediate course. Filter Uncertains		·
executed an and rial-transit	Cause (Disease or injury that initiated events c		
physician and strength burial-transit coloral Examir	resulting in death) Last Due to (or as a consequence of):	
cate be physicial the burn	d		
ertifica ing ph e as t	IF FEMALE:		
e death certing the attending led for use a sician/M	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
res that the death certification by the attending I be detached for use as by Physician/Me	1 □ Yes 2 PNo 4□ Pregnant at time of death 9 □ Unknown	5 Other (specify)	
s that hed by deta	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
w requires to the second be considered by			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown
aw reas bee			24a. Was an autopsy findings available prior to completion of cause of
ystcian: The law requires is certificate has been s director, page 2 should			autopsy prior to completion of cause of performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
ician: Th certificate ector, pag	25. Was case referred to medical examiner?	26. Place of De	ath (Check only one)
Physic this of al dire	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp		lome 5 ☑ Residence 6 □Other (Specify)
Attending Pherector: After the by the funeral	Table de la contraction de la	ne of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
ttend death ctor: y the	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be classified 28e. Place of injury - At home, fam		28f. Location (Street and Number or Rural Route Number,
tal or Attending F s after death. al Director: After led in by the funer. Certification:	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, State)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	29a. Certifier 1 △ Certifying Physician: To the best of my knowledge, (Check only one) 1 △ Certifying Physician: To the best of my knowledge, and manner stated.	death occurred at the time, date and plac for investigation, in my opinion, death occ	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
ro the orther comple	29b. Signature and title of certifies.	29c. License number	29d. Date signed (Month, Day, Year)
- ×-	- Kerkanni	D35792	June 25, 2008
10 4	30. Name and address of person who completed cause of death (Item 23a) (T		
10		-4	Rockville, Maryland 20852
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Soule	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** June 24, 2008 Ruth May Hardt 6:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glynn Taff Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖾 F Months Min. 212-03-6154 96 May 30, Director 1912 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination in Item to multifled an once. Director 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5741 Edmondson Avenue 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: ð 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant C&P Telephone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Lippert Caroline Hoffman မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack T. Hardt Son 4 Old Dominion Court; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Good Shepherd Cem. 6/27/2008 4 ☐ Donation 5 ☐ Other (Specify) Ellicott City, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as attending IF FEMALE. for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ g 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTIG LIVING 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c 28d. Describe how injury occurred Injury at Work? or Attending 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) 29b. Signature and title of certifie

Registrar

31. Date filed (Month, Day, Year)

GIEETHA RAJA MD

JUN 2 7

32 Registrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

29c. License number

127541

use or death (ITEM 23a) (Type, Print) 4367 Hollins Ferry Rd, Suite 4A, Baltimore, MI)-21827.

29d. Date signed (Month, Day, Year)

June 25, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. APID TIPM 20b, per FH (\$80.6/27/08 US State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Charles Vernon Hachemeister 1:23 am June 24, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harbor Hospital Baltimore 7. Age (In yrs. last birthday)
73 Yrs. Social Security Number 215–30–9254 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/28/1934 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 ☐ F MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore MD 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 21230 1317 Hull Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 注 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Steel Company es 1 and 2 should be filed w of Health and Mental Hygier f item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jeanette Fritz George J. Hachemeister other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1317 Hull Street, Baltimore, MD 21230 19a. Informant's Name/Relationship (Type. Print) Ella Mae Hachemeister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Rayview Crematory

Bayview 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of H Important: If ite any injury or of 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD 6/28/2008 4 □ Donation 5 □ Other (Specify) ature of Euneral Service Licensee 22. Name and Address of Facility Victor Charles L. Stevens Funeral Home Inc 1501 Fast Fort Avenue, Baltimore, M **Doda** 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NOI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical use as the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö the detached 9□Unknown the 9 Unknown þ ے The law requires that signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 NO 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔀 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division Hospital or Attending Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the date of the cause of t 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Tot 45105 10

State Registrar

0

31. Date filed (Month, Day, Year)

01

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Maryland

Baltimore,

:55

2008

Box 68760

Records.

or Vital

ISAACSON

ELIZABETH

			For State	State of Ma	aryland / Dep		of Health a of Death	and Me	ntal Hyg	iene _{eg. No} 2 (ากล	209	203
			Registrar Decedent's Name (First, Middle, Last)		Timouto	or Beatin	2.	. Date of Deat		, , ,	3. Time of	
- 67	Physicia	an	Cecil J. Joseph						Month une 24	Day	Year	9:12	AM
	/Medic	2	4a. Facility Name (If not institution, give			4h. City. Toy	wn, or Location of		une 24	1	ity of Death	1	A
	Examin	er	Southern Maryland			Clinto						orge's	
	Funeral	(.)	5. Social Security Number 6. Se		e (In yrs. last birthday) If Under 1 Y	ear If Under 2		Date of Birth		9. Birth	place (State o	
	Director]M 2□F 8	36 Yrs.	Months D	ays Hours	Min. J	(Month, Day, an. 30	1922	Con	York,	
in	the term of the terms		Usual Residence of Decedent										
	rylan how Lat	L	10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside Ci	-
	e Ma ta-f s	cto	New York		New Yor	ζ						1 X Yes	2 No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Co	ode		1	0g. Citizen d	f What Cou	ntry?	
	ath w	ra La	129-133 West 147th			1003				U.S.A.			
	tems	nue	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	Was Decedent If Yes, specify	t of Hispanic Orig Cuban, Mexican	gin? (Specif i, Puerto Ric	y Yes or No- can, etc.)		ace - Ameri lack, White		
36	or i	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	1946	1 □ Yes 2 X	No Specify:			Spec	cify:		
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9	filed Hyg other ent, t		17. Father's Name (First, Middle, Last)					r's Name (F	irst, Middle, M	/aiden Surn	ame)		
an	ld be ental ked (To Be	Bertie Joseph				Mab1	le LaJ	uene				
Maryland 21215-0036	shound Mind Mind Mind	-	19a. Informant's Name/Relationship (7)	rpe. Print)	19b. Mai	ing Address (Si	treet and Numbe			, City or Tow	n, State, Zi	p Code)	
ž	nd 2 lith a 27 Is 27 Is r trau		Marsha King (Ni	ece)	P.0	ь b0х 7	42 Gree	enbelt	, MD 2	0768			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		20b. Place of Disp		of	Date		20c. Location	n - City or T	own, State	
9	Page ent o nt: If ry or		1 Burial 2 □ Cremation 3 □ I 4 □ Domation 5 □ Other (Specify,		Calverto		· i	6/3	0/08	Calve:	ton.	NY	
薑	artm ortar Inju	ŀ	21. Signature of Funeral Service Licens										
ñ	Dep Imp any onc		1 X January (pt	Marian		2352 8ti	ddress of Facilia uneral C h Ave.,	New Y	ork, N	Y 1002	27		
			23a. Part1. Enter the disease, or comp	ications that caused	the death. Do not e	nter the mode o	f dying, such as	cardiac or r	espiratory arre	est,		Approximat Interval Bet	e
	Physician		shock, or heart failure. List only o		ardiac (W/ illhui.						Onset and	Death
	/Medical		disease or condition resulting in death)	a	a consequence of):	The girthuce							-
	Examiner			•		161,67	as						
T)	— -	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):								
ing.	outed d ansit	Examiner	that initiated events	2.	END ST	Af 1	lend o	dis					
V	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	END 57 a consequence of):) (Gleles		, ,						
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မွ	rtifica ng ph as th	Med											
Вох	th ce endir	N/ne	230. Was decedent pregnant	23c. If yes, outcome		□Ectopic pregr	nancv				Date of deliv		V
	e dear	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a		Other (speci					Month	Day	Year
P.0	at the by the	μ̈́ς	9 ☐ Unknown										
Ś	The law requires that the death certific the has been signed by the attending p tage 2 should be detached for use as	by	Part II. Other significant conditions co	ntributing to death b	out not resulting in the	underlying caus	se given in Part I.					the cause of c	/
ord	sen s	ted			-				1 🗆 Ye	es 2 No	3 Pro	babiy 4 🔼	Unknown
ec C	e law i has be	Completed							24a. Was a autops	n 24	b. Were aut	opsy findings ompletion of c	available ause of
<u>~</u>		, m							perform	ned? 2 No	death? 1 ☐ Yes		
/ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?				26. Place	of Death (Check only on	e)			
>	this call dire	2	1 Yes 2 No	Hospital: 1 1 Inpatie				rsing Home	5 Reside	ence 6 □(Other (Spec	ify)	
Division or Vital Records,	fter mer		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time y Year) Injury		Injury at Work?		d. Describe ho	ow injury occ	urred		
Sio	Attendideath.	ati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М	1 ☐ Yes 2 ☐ I	-					
Ξ	or Att	Certification:	4 ☐ Homicide determined	28e. Place of inj building, et	ury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, σ	ffice	281	f. Location (St City or Town	reet and Nu. n, State)	mber or Rui	rai Route Nun	nber,
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	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		iner: On the basis of	of my knowledge, de of examination and/or								s)
	thin 2	Med	29b. Signature and title of cartifier	and manner st	ated.	29c. L	icense number		2	9d. Date sig	ned (Month	, Day, Year)	
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	D		30. Name and address of person who c	ompleted cause of c		Ha a ca	2564 Ave	GF	S. L.	ZIN I	Doch :-	ton N	2005
	Sta	te	31. Date filed (Month, Day, Year)	32. Registi	ar's Signature	thern	AVC	UF	JULITE	510.0	- COMINS	1011 0	_
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 20904 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dan B. Jordan, Sr. June 24, 2008 16:17 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 21, 1939 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 349-32-2795 68 Georgia Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, it is No Jicol Ext. in or must be notified at 1X Yes 2 No Director Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 821 Lynn Court 20850 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐Yes 2 XI If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed wi h and Mental Hygier 7 Is marked other th 3 Analyst TBM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Enoch P. Jordan II Alida Bartlett ဂ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any injury or other traun once. Sandra L. Jordan/Wife 821 Lynn Court, Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rockville Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State June 28, Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility Robert Rockville, Inc. 300 W Rockville, MD 20850 rt A. Pumphrey Funeral Home/ W. Montgomery Ave. 21. Signature of Funeral Service Licensee M01346 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac Arrest Immediate disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 Years Coronary Artery Disease Sequentially list conditions, if any, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Diabetes Mellitus 10 Years ending physician and use as the burial-transi Exami resulting in death) Last Due to (or as a consequence of): End Stage Renal Disease 10 Years Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached it Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ₹ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hyper Lipidenia 24a. Was an certificate has autopsy performed' Division of Vital 1∐Yes 21∑No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 No 1 ☐ Inpatient 2 ី ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No of or Attendation of the death of Director: 2 ☐ Accident the f 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signatur 29d. Date signed (Month, Day, Year) and title of ce 08 D0051779 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Cullen, M.D., 6000 Executive Blvd. #300, Rockville, MD 20852 <u>William</u> 31. Date filed (Month, Day, Year) State Registrar

braan

Amend #5, perInf G881, //1/08 TT Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** P M Carolyn B. Jones 24 2008 June 2:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Good Samaritan Assisted Living Silver Spring
If Under 1 Year | If Under Montgomery 5. Social Security Number (In vrs. last birthday 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 □ M 2 🛛 F 223-66-3012 Director 66 <u>December 11,1941 West Virginia</u> Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 √ Yes 2 No Directo Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural', or items 23a dical Examiner must b permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must 20850 by Funeral 613 West Lynfield Drive United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify Specify: 3 to Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Accounting Staffing Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Theodore H. Bennett Thelma Bennett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8600 Snowden Loop, Laurel, Maryland 20708

B of Disposition (Name of Date 20c. Location - City or Town, State Richard G. Noland/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Montgomery Crematorium, Inc June 27, 2008 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville Inc. a Rock MO1532 300 West Montgomery Ave., Rockville, Maryland 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physiclan** HYDDYEWIR GHOUNS resulting in death) /Medical Due to (or as a consequence of): Examiner MONTHS METACIPIIC ADENOCAKEINOMA OF LUNC Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perform this certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) l in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>ca</u> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 Ma Delia Roddy Fine, M.D. 8120 wow. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8120 Woodmont Ave., #320, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 2008 State Registrar

08-04723 Cassandra Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 20906

33a	idia Johns	1	- For State Certificate C	of Death	Reg.	
	Physicia	_	egistrar 1. Decedent's Name (First, Middle,Last)			3. Time of Death
	Exami	ner	Cassandra Johnson	4b. City, Town, or Location of Dea	June 19, 200	14c. County of Death
			4a. Facility Name (if not institution, give street and number)	Frederick	2(1)	Frederick
			Frederick Memorial Hospital 5 Social Security Number	If Under 1 Year If Under 24h	Irs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
	Funeral	1	200 04 7460		in. 04/14/	I Foreign
	Director		296-64-7462 1 M 2 M F	rs.		
	any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc			10d. Inside City Limits
	* 4	Ì	VA Loudoun	Potomac Fall	S	1 X Yes 2 No
8	faryland 28a-f show I at once.	흱	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	e Maryland or 28a-f sho	Director	20376 Clover Field Terrace	20165		USA
3	L 13-UU30 be filed within 72 hours after death with the Maryland Hall Hygiene. rked other than "natural", or items 23a or 28a-f sht ent, the Medical Examiner must be notified at once	ä	11. Manital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin?	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
1	ath w	Funeral	1 Never Married 2 X Married Armed Forces?	f Yes, specify Cuban, Mexican, Pue	eno Rican, etc.)	Black
	fer de		3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2X No specify:		Specify:
	ours a	d by	(C t bisheet grade completed) 16a Dece	dent's Usual Occupation (Give kind most of working life. DO NOT use		6b. Kind of Business/Industry
	72 hc n "ng al Ex	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	inistrative V.P.		Health Care Services
ć	5-0030 iled within 72 Hygiene. I other than "	ompleted	12		ame (First, Middle, Ma	aiden Surname)
L	Hygin the I	ျပ	17. Father's Name (First, Middle, Last) John William Hood Sr.		Elizabeth	
3	ZIZIO-003 LIZIO-003 ould be filed withir Mental Hygiene. marked other th ic event, the Medi	o Be	47a Informant's Name/Relationship (Type Print) 19b. Ma	iling Address (Street and Number	or Rural Route Numb	per, City or Town, State, Zip Code)
	shoul and N and N 7 is m	ĭ	John William Hood Sr. / Father 51	4 Central Avenue	, Mansfie	Ld,ıOH 44905
	MOOFE, INIO ZIZIS Pages 1 and 2 should be fil nent of Health and Mental E ant: If item 27 is marked or other traumatic event,		20a. Method of Disposition 20b. Place of Dis	position (Name of cemetery,	Date	20c. Location - City or Town, State
	Ore ges 1 t of H			rother place) eld Cemetery 6	/28/2008	Mansfield, OH
	Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra	1.5	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Dorota Marshall	2 Name and Address of Facility		
	Depa Depa Impo	0			vens Fune:	ral Home Inc.
	ysician		23a. Part I. Enter the disease, or complications that caused the death. Do not en	er the mode of ying, such as car	ac of residual of various	
	Jedical		failure. List only one cause on each line. Immediate Cause (Final disease a Concentric left ver	tricular hypert	rophy	Death
	Examiner		or condition resulting in death) Due to (or as a consequence of):			
			Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
		ine	cause. Enter Underlying Cause			
		Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The law requires that the death certificate be executed the Physician and the Funeral Director: After this certificate has been signed by the attending physician and makedy files the funeral director mass 2 should be detached for use as the burial - transit	一色	d#220_27_port	G 6881 7/31/08	тт	
	60, ate be exe physician he burial -	edical	X UNPENDED X AMENDED #23a,27, per FH. g88	33.9718708, WS A	mend #7 Pe	er Inf G8871/07/09 JH
	760 icate l iphys	≥	IF FEMALE: 23c. If yes, outcome of pregnancy	Fetal death 3 Ectopic p		Month Day Year
	Sox 687 Jeath certific e attending p	ciar	past 12 months? 4 Pregnant at time of death 5	Other (Specify)		
	30X death he atte	Physician	1 Yes 2 No 9 Unknown g Unknown		Da Did to	obacco use contribute to the cause of death?
	at the	1		the underlying cause given in Part		s 2 No 3 Probably 4 V Unknown
	res th signe	a p			24a. Was	CONTRACTOR OF THE PROPERTY OF
	rds requi been bould	lete			autor	
	e law te has	ompleted by			1 Ves	
	- R	၂ပိ	35 Was saco referred to medical	26.Place of Death (C		
	/ita ysicia his cer	B	examiner? Hospital: Inpatient 2 🗸 ER/Outp		Nursing Home 5	Residence 6 Other:
	Of \officers		27 Manner of Death 28a. Date of Injury 28b. Tim	e of Injury 28c. Injury at Work?		how injury occurred
	on sath.	į	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 1		To a d Alumber of Dural Pouto Number Cit
	Visi r Att fer de fleete		2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	, street, factory, office building, etc.	28f. Location or Town,	Street and Number or Rural Route Number, Cit State)
	Dital of ours at Disagrams	Certification:	4 Homicide determined (Specify)			() and manage or stoted
	Hosp 24 hc Fun	2 2		occurred at the time, date and place	e, and due to the cau urred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Finners Director: After this certificate has been signed by the Finners of the finners in the finners of increase should be detached it	Medical	and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)
		2	29b. Signature and title of certifier	O.C.M.E.	OCME	June 20, 2008
			I hoder My KIRTHY W	0.0.W.L.		
		1	30. Name and address of person who completed cause of plath (fem 23a) Theodore M. King, Jr., MD. Assistant Medical Examin	er 111 Penn Street, Ball	timore. MD 2120	01
			2 Penistrar's Signature			
	Reg	Stat	e on bate mod (monal, boy), real,	ede		
_				SINAL		
D	-IMH 17 Rev	1/200		21177 No.		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year MARY JENKINS 8.55 A M /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNION MEMORIAL HOSPITAL N/A BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number Date of Birth (Month, Day, Year) 9-3-1926 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F MARYLAND 220-30-2563 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 1√∑Yes 2 □ No N/A MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2113 BOLTON ST. 21217 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 □ Widowed 4 ₺ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER CAMP MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ GEORGE E. MADDOX AUGUSTA M. YOUNG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2113 BOLTON ST. BALTIMORE, MARYLAND 21217 THOMAS INA MERCER (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial # ☐ remation 3 ☐ Removal from State NEW CATHEDRAL CEMETERY 6-30-2009 BALTIMORE, MARYLAND 4 □ Donation 6 ☐ Other (Specify) D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic Obstructive Alchour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be execute nding physician and use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 ☐ Other (specify) а∏Unknown 9 Unknown ρ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Dichetis Mellitos The law 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Avenia certificate 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury after death.

I Director: At d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Thomicide within 24 hours a To the Funeral I To the Hospital 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D0059056 DALJEET SALUJA MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 falls Rd Belt Mo Seclure 36(2 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20908 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1^{Day} 2008 Physician JOSEPH KNOX JUNE 24, 8:46A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day) **Funeral** Days Min. Hours 1.XM 2□ F -36-0 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Examiner must be notified at 1 Yes 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 0 "natural", or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race -Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☑ Divorced Blace Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 (Sister) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Bennl 10. 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 22. Name and Address of Facility
Joseph L. Russ
2277 W. Worth 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or hear failure. List only one cause on each line.

Immediates or condition resulting in death)

a.

Due to (or as a consequence of): Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò pe 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 s autopsy performed? Yes 2/1 No certificate Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2× No Hospital: Other: 4 Nursing Home Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

within 24 hours after deatl To the Funeral Director; completely

> State Registrar

29b. Signature and title of certifier

11119 31. Dale filed (Month, Day, Year)

JUN 2

DHMH 17 Rev 1/2001

MD

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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32. Registrar's Signature

		1	For State Registrar	State of M	Ce	rtificate of	Death	ментат ну	gierie A Reg. No.	2008	20909
Phys /Me	iciar dica	1	1. Decedent's Name (First, Middle, La			Lydard		2. Date of De Month June	ath Day 24	Year 2008	3. Time of Death 11:00 P M
Exam	ninei	4	4a. Facility Name (If not institution, giv	ŕ		4b. City, Town, o	r Location of Death	1	4c. Coun		
			Frederick Memor:			Freder				rederick	
Funer Direct			5. Social Security Number 6. S 219-10-0850 Usual Residence of Decedent	M 2 XF 7. Ag	ge (In yrs. last birthday) 82 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	th y, Yea <i>r)</i>)7/192		lace (State or Foreign try)
aryland show d at			10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
he M 28a-f otifie	Director		MD Freder	ick	Frederi						1 □Yes 2√No
with t	ż	5	10e. Street and Number			10f. Zip Code		1	10g. Citize	n of What Coun	try?
s 233	27.0	5	6441 Jefferson F		F	21703			USA	_	
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natura"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	hy Funeral	2	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 → No		pecify Yes or No o Rican, etc.)		Black, White,	etc.
2-0 2 ho	Pat	3	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occup	ation		_16b. Kind	Whi of Business/Inc	dustry
215 Ban "r Med	Completed	-	(Specify only highest gra	College (1-4or	life	kind of work done of DO NOT use retired	during most of world i)	king			inty Board
21 ad with a signer of the sig	١	Ē _	12		' I	retary			ot E	ducati	on
al High	Ba		17. Father's Name (First, Middle, Last,)		-	18. Mother's Nam	ө (First, Middle,	Maiden Su	ırname)	
Maryland 1d 2 should be file Ith and Mental Hy 27 is marked oth traumatic eveni	F		Clarence Thomps	on			Mary E	ons			
and ls ms	- 1		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or T	own, State, Zip	Code)
and alth			Gloria Anna Lydar	d/Self	644	1 Jeffers	on Pike	Frederic	ck, MI	21703	
Baltimore, bermit. Pages 1 a Department of Hee mportant: If Item any Injury or othe		2	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specif</i>		20b. Place of Dispo cemetery, crea	osition (Name of matory or other plac	ce)	Date Jun 26	20c. Loca	tion - City or To	wn, State Maryland
Balti permit. Departmimportal	once.		21. Signature of Funeral Service Licer			ake Crema 2. Name and Addres Cremation	ss of Facility and Funer	al Alter	nativ	es	•
Physicia /Medica Examine	al		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Se Due to (or	the death. Do not entre. SIS a consequence of):	ter the mode of dyin	Pastures g, such as cardiac	Drive or respiratory ar	Balti rrest,	more, Ma	Approximate Interval Between Onset and Death
rificate be executed g physician and as the burial-transit	cal Examiner		Sequentially list conditions, fand the conditions of the condition	c. Due to gras	a consequence of): a consequence of):		le Uli	tu			DEEKS
the death ce y the attendir ched for use	Physician/Medical	1 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			230	d. Date of delive Month	ry Day Year
w requires that is been signed be should be detailed	à	'	eart II. Other significant conditions o	ontributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.				e cause of death?
	Completed	-						24a. Was a autop perfor 1 Yes		24b. Were autop prior to con death? 1 ☐ Yes	osy findings available inpletion of cause of
VICAL P sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat				
	10 E		1 ☐ Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/Outpatien	t 3□ DOA Othe	er: 4 🗆 Nursing Ho	ome 5 Resid	lence 6	Other (Specify)
for Attending Phy after death. Director: After this in by the funeral di		2	7. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b. Time of Injury	Work		28d. Describe h			,
LIVISIO tal or Attend s after death, al Director: /	Certification:		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injubulding, etc.	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office		28f. Location (S City or Tow	treet and N n, State)	lumber or Rura	Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (29a. Certifier 1 ★ Certifying Ph (Check only 2 ← Medical Exan	ysician: To the best niner: On the basis of and manner sta	of my knowledge, deatl f examination and/or in ated.	n occurred at the tim vestigation, in my o	ne, date and place, pinion, death occur	and due to the dred at the time,	cause(s) ar date and pl	nd manner as st ace, and due to	ated. the cause(s)
To t To th	M	2	9b. Signature and title of certifier			29c. License		3	29d. Date s	igned (Month, L	Day, Year)
20			Name and address of person who of PAAYEEN BOLAT		eath (Item 23a) (Type,	Print) ORIVE	FREDER	ICK, M	0 - 2	21782	
S Regis	tate strar		11. Date filed (Month, Pay, Year)	32 Registr	ar's Signature	sell i					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year avid 06 10:25 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Medical Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days 13€ M 2 ☐ F Director 213-07-3124 91 March 1,1917 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f show Examiner must be notified at MD Baltimore Dunda1k Director 1 ☐ Yes 2 € No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1701 Holaview Road Apt. A-4 items 23a 21222 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Tety'es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ò 1 ☐ Yes A No ģ 3 □Widowed 4 □ Divorced SpecifyWhite "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor <u>Bethlehem Steel</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked William Leisure Margaret E. Crispens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice E. Stulich- Daughter 2964 Cornwall Road Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 4 Donation 5 Dother (Specify) 6/24/2008 Baltimore, Maryland 22. Name and Address of Facility Charles S. Zeiler & Son Funeral Home 21. Signature of Funeral Service Licensee 6224 Eastern Ave. Baltimore MD 21224 23a. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart is little ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**N**0 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

State

29a. Certifier (Check only

ee Ann

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Nagner

10N-Greene

egistrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c, License number

Street

29d. Date signed (Month, Day, Year) 06-18-2008

Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Year 7:00 p /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner GrANCEVIEW 125V:112 ora Social Security Number 7. Age (In yrs. last birthday) If Line 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 18 Months Days Hours Min. 83 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

12. Yes 2 No
17 Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify. 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Ihu Magany Injury or other traumatic event, Ihu Magany Injury or other traumatic event, Ihu Magangore. Elementary/Secondary (0-12) College (1-4or 5+) HE195 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be orier ပ aaret 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pulesville 4002 Grandeview rnd ıllıan 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Chapel 4/24/08 Forest Hill Donation 5 Dother (Specify) 22. Name and Address of Facility EVANS Funeral Chapert i initia. of Furthral Strv. Licensee RO rootemen Services 3 Newport Dr. Forest Hill my 21050 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final month **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy the Hospital or Attending Physician: The certificate performe Division of Vital 1 □Yes 2 No 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral filled in by t 2 Accident investigation 1 ☐ Yes 2 No Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Dr Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check one) within 2 To the I 29d. Date signed (Month, Day, Year)
June 26th, 2008 29b. Signatu and title of certifier 29c. License number 045390 . Name and address of person who completed cause of death (Item 23a) (Type, Print)
WIO Min /M-D: 944 Philedelphia Road #208, Balfimore, MD 2123

DHMH 17 Rev 1/2001

State Registrar 32.

Registrar's

			Please	e Type or Prin							_	
			for State Registrar	State of Ma	aryıan		rtment of F tificate of I		Mental Hy		71111	20912
			Registrar Decedent's Name (First, Middle, I	Last)			imeate or i	Douin	2. Date of De	Reg. No.		3. Time of Death
	Physicia		Robert J.	Mart	in				JUNE 500e	Day	7 200 2	8 138 64 PM
	/Medic		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	Location of Deat			County of Deat	
	• • • • • • • • • • • • • • • • • • • •		Baltimore Wes					n Burn				Arundel
	Funeral		5. Social Security Number 6. 031-22-2486	Sex	e (In yrs. i 87	ast birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, D	ay, Year)	9. Birti	hplace (State or Foreign untry)
и.	Director		Usual Residence of Decedent		07				May 1	.9 19	21	MA
vland	how		10a. State 10b. County		10c. City	, Town or Loc	ation					10d. Inside City Limits
e Ma	8a-f s	cto		Arundel				n Burnie				1 ☐ Yes 2 ☑ No
with #	a or 2 be no	Funeral Director	10e. Street and Number 7008 Cresthav	en Drive			10f. Zip Code	21061		10g. Citiz	en of What Co	-
eath	ns 23, must	eral	11. Marital Status	12. Was Decedent I	Ever in U.	s. 13. W	/as Decedent of H		necify Yes or No	n- 1	4. Race - Ame	JSA rican Indian.
o ffer d	r iten	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces?		_	/as Decedent of H Yes, specify Cuba		to Rican, etc.)		Black, White	
Sours a	ral", o Exan	l by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	196		☐Yes 2☐xNo	Specify:			Specify: W	Thite
٦ م م	"natu dical	etec	15. Decedent's (Specify only highest of	Education grade completed)		(Give k	ent's Usual Occup	during most of wo	rking	16b. Kin	nd of Business/	Industry
	ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		ONOT use retired hief Pet	•	ar	IIn	i+03 C+	ates Navv
IIIG ZIZI3-UUSO be filed within 72 hours after death with the Marvland	Hygir other ent, th		17. Father's Name (First, Middle, La	st)			1101 100	18. Mother's Na				ates Navy
	lenta rked tic ev	To Be	Ora R. Ma	artin				Grac	e J	James		
short	and N Is ma		19a. Informant's Name/Relationship	(Type. Print)			g Address (Street					(ip Code)
and s	ealth m 27 her tr	١.,	Marilyn Keen	(daughter)			Kenton I	Road, Pa				
ides 1	Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		0	emetery, crem	ition (Name of atory or other plac	1 7 7 -	• .	20c. Loc	cation - City or	Town, State
Dallillo	intmer injury		4 □ Donation 5 □ Other (Special Signature of Funeral/Service Lie		. Mai		Veterans Name and Addres		008			e, Maryland
	Depa Impo any ir		Mush.	12/10,	~ ~	\	3111 Mour					ome, P.A.
			23a. Part . Enter the diseas , or co shock, or heart failure. List on	mulications that caused	th death						, 112 21	Approximate Interval Between
Pł	nysician		Immediate Cause (Final disease or condition	Some cause on each in	310							Onset and Death
	Medical xaminer		resulting in death)	Due to (o as	a cons qu	ience of):	1 0	* 27 1				
<u>-</u>	xammer	<u></u>	Sequentially list conditions,	b. HSce Due to (or as	Ndi	MY C	polsi	91725				
ted	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	60119	a consequ	A 1	Si Can Ca	7 0				
c, executed	been signed by the attending physician and should be detached for use as the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequ	ience of):	A MANY TO					
ficate be	nysicie he bu	ical		d								
ertifica	ling ph e as t	Physician/Medical	IF FEMALE:									
aath cer	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3 🗌	Ectopic pregnancy	,		2	3d. Date of deli Month	ivery Day Year
the de	the ched	ysic	1 □ Yes 2 🗷 No 9 □ Unknown	4□Pregnant at 9□Unknown	time of de	aun 5	Other (specify)					
s that	ned by deta		Part II. Other significant conditions	contributing to death bu	ut not resu	ılting in the un	derlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
w requires t	en sign	Completed by	Atrial Fibr	Mation					1 🗆	Yes 2	No 3∏Pr	obably 4 Unknown
a ve	22 Q	plet	Coronary Ar	ten bis	ea St	0_			24a. Was		24b. Were au	topsy findings available completion of cause of
_ P	s certificate has b lirector, page 2 s	Com	Dinbetes 1	latetus						ormed? 2 X No	death? 1 ☐ Yes	
V ILO	ector,	Be	25. Was case referred to medical examiner?	Heapital: A			1011	26. Place of Dea	ath (Check only	one)		7
Phys	ral dir	- To	1 ☐ Yes 2 No 27, Manner of Death	Hospital: 1 Impatie		ER/Outpatient 28b. Time of		4 LI Nursing F	lome 5 ☐ Res			cify)
ding	h. After fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day	Year)	Injury	28c. Injur Worl	yat k? Yes 2∐No	Zod. Describe	now injury	occurred	
Atten	r deat ector by the	ifica	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of inju	ıry - At ho	me, farm, stre			28f. Location (Street and	Number or Ru	ıral Route Number,
<u>a</u> <u>p</u>	al Dir	Certification:	4 Difformate	building, etc	з. (Зреспу	′)			City or 10	wn, State)		
othe Hospital or Attending Physician: The law requires that the death certificate be	within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying I	Physician: To the best of aminer: On the basis of	examinal	wledge, death tion and/or inv	occurred at the tire estigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
o the	vithin 2 o the omple	Med	29b. Signature and title of certifier	and manner sta	ileu.	_	29c. License	e number		29d. Date	signed (Monti	h, Day, Year)
_	> F 0		b/ land	11 11	1		N.	59919		Tours	1 200	4 200
	241		30. Name and audress of person wh	o completed cause of de	eath (Item	23a) (Type, F	Print)	11111		Juy	2 23)
,	10	70	Julius C. Pl	1am 301	No	spra	Dr	6 lou 13	SINFL	_11	D 20	9 2008
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registra	ar's Signal	le Con	sele!)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 22, Mary Elizabeth June 2008 Marvel 6:40 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Elder Care Severna Park Severna Park Anne Arundel Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Dec. 15,1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Days Months Hours 1 M 2 X F 214-18-7203 88 Dec. MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a State 1 □Yes 2 No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 403 W. Ordnance Road 21061 U.S.A. Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. was Decedent Ev Armed Forces? 1 □Yes 2X No If Yes, Give Year or Dates: Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Specify: Specify: ۾ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be August Hastman Mary Elizabeth ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Lou Briggs/Daughter 310 Autumn Creek Drive Senoia, GA. 30276 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition June 27, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial: Elkridge, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses Services 1 2nd Avenue SW Glen Burnie, MD 21061 1201357 23a. Part 1. Et al. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ Ho 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 M Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

burial-transi P.O. Box 68760, nding physician use as the signed by the a d be detached for Division of Vital Records, page 2 should funeral (To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

3altimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1)2

32/Registrar's Signature

UY

Bonh

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Check, Mad 21619

			1 - For State Registrar	State of	iviaryiai		rtificate c	f Health and of Death		giene Reg. No. 🤈 N	0.8	20011
65	Physic /Medi		1. Decedent's Name (First, Middle, Ruth Mi	ast) 11er				-	2. Date of Dea Month June 2	ath 2008	-	3. Time of Death 8:550m
	Exami		4a. Facility Name (If not institution, g					n, or Location of Dea		4c. County		
	Funeral Director		062-20-1051	Sex 1 1 M 2 F	7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Ye Months Da			h		place (State or Foreign htry) NY
	Maryland -f show fled at	tor	Usual Residence of Decedent	mery	10c. Cit	ty, Town or Lo		nesda			1	0d. Inside City Limits 1 XYes 2 No
	th with the 23a or 28a ist be noti	Funeral Director	10e. Street and Number 4925 Battery I	ane			10f. Zip Cod	20817		10g. Citizen of	What Coun	itry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced	12. Was Dece Armed For 1 Tyes If Yes, Give Year or Da	ces? 2 🔀 No e		Was Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Rad Bla Specif	ce - Americ ck, White, o y: Whi	etc.
21215-0036	within 72 ho ene. than "natu i ne Medical	Completed by	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		-4or 5+)	(Give life, L	dent's Usual Oc kind of work do DO NOT use re chool Te	ne during most of wo ired)	orking	16b. Kind of B	usiness/Ind	•
Maryland 2	uld be filed valental Hygid rked other tic event, the	To Be Co	17. Father's Name (First, Middle, La Samuel Hendler	st)			.1001 16	18. Mother's Na	me (First, Middle, chmertzle	Maiden Surnar		л
	and 2 shot saith and N 27 is ma er trauma		19a. Informant's Name/Relationship Sharon Ward / D					eet and Number or R ory Bend T				
Baltimore,	Pages 1 ment of He lant: If iten lury or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	cify)	Mou	int Leb	sition (Name of natory or other) anon Ce		Date 5/25/2008	20c. Location	•	wn, State
Ball	Depart Import any In		21. Signature of Funeral Service Lic	W-Ma	ulla	U L	Charles	dress of Facility L. Steve St. Fort. A	venue.1 B	altimor	Inc.	21230
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death Congestive Heart Failure a. Congestive Heart Failure Due to (or as a consequence of): b. Due to (or as a consequence of):									
68760,	rificate be executed ig physician and as the burial-transit	edical Examiner	if an, leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or as a conseq							
O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2□Feta ant at time of d	l death 3□	Ectopic pregna Other (specify)				te of delive	ry Day Year
ords, P.	w requires that been signed by should be det	by	Part II. Other significant conditions Dermatom		ath but not resi	ulting in the ur	deriying cause	given in Part I.	23e. Did to	32		e cause of death? ably 4 ∐Unknown
al Records,		Completed				-			24a. Was a autop: perfor 1□ Yes	sy		psy findings available npletion of cause of 2 \square No
Viita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Mhaa	ath (Check only or			
Division or	Ing Phy After this uneral d	ıtion: To	1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date o		ER/Outpatient 28b. Time of Injury	28c. Ir	4 ☐ Nursing I	dome 5 Resid) hospice
DIVIS	i i ite	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	N 28e. Place of	of injury - At ho g, etc. (Specify	ome, farm, stre	eet, factory, offic	ce	28f. Location (S. City or Town	treet and Numb n, State)	per or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical (29a. Certifier 1 XCertifying F (Check only one) 2 Medical Ex	Physician: To the laminer: On the ba	sis of examina	wledge, death tion and/or inv	occurred at the restigation, in m	time, date and plac y opinion, death occ	e, and due to the curred at the time, c	cause(s) and madate and place,	anner as sta	ated. the cause(s)
	Most Com	Σ	29b. Signature and title of certifier	Indle	2 5%		D	nse number 0064615	2	9d. Date signe June	d (Month, L 23, 2	Day, Year) 008
	þ		30. Name and address of person wh	ewski, M.	D. 600	1 Munc		ill Road,	Rockvil:	le,1 MD	20855	
	Sta Registr		31. Daye filed (Month, Day, Year)		gistrar's Signa	ture Anexe	16.1					

08-04827 Anne Bishop Offutt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

20915 2002

ie bisnop O	11011	1- For State	Certificate	of Death	Reg. No		
Physic	ian/	1. Decedent's Name (First, Middle,Last)			Date of Death Month Day	Year	3. Time of Death 0849 hrs
✓ I Exam	iner	Anne Bishop Offutt		The state of Dooth	June 23, 2008	4c. County of Death	00-10 1110
		4a. Facility Name (if not institution, give stre 306 Lord Byron Lane Apartme		4b. City, Town, or Location of Death Cockeysville		Baltimore Cour	ity
			7. Age (In yrs. last birthda		. 8. Date of Birth(MI	M/DD/YYYY) 9. Birth	place (State or
Funeral Director		0.000.0.000.0	m o	Months Days Hours Min	April 6.	1958 Foreign	place (State or Baltimore, htryMaryland
Director	,		2 - F	Yrs.	<u> </u>		
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	ocation			10d. Inside City Limits
		Maryland Baltimore	County Cockeys	sville			1 Yes 2 No
arylan Sa-f sl	왕	10e. Street and Number		10f. Zip Code	10g. C	citizen of What Coun	ry?
vith the Maryland s 23a or 28a-f show s notified at once.	Director	306 Lord Byron Lane	Apt.T2	21030		nited Sta	
with to	<u>re</u>	11. Marital Status	. Was Decedent Ever in U.S. 13 Armed Forces?	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,
death r iten	Funeral	1 Never Married 2 Married 1	Yes 2 No		,	Wh:	ite
after	J A	3 Widowed 4 Divorced If Y	Dates:	1 Yes 2 No specify: cedent's Usual Occupation (Give kind of	work done 16	Specify: b. Kind of Business/Ir	ndustry
hours natur Exam	Pe	15. Decedent's Education (Specify only h	College (1-4 or 5+)	ring most of working life. DO NOT use ref			
36 in 72 han "	ompleted	Elementary/Secondary (0-12)	N/A	Home Maker		Own Hor	ne
d with		17. Father's Name (First, Middle, Last)		18.Mother's Nam	e (First, Middle, Maid	len Surname)	
215 e file tal Hy ked o	Be C	David Reid Fauntle	roy		rie Cocke		
21, ould bould by Men	2	19a. Informant's Name/Relationship (Type		Mailing Address (Street and Number or			
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene whatural", or items 23a or 28a-f sho		Mrs. Sara B. Turek	(200511001)	55 Towngreen Way Disposition (Name of cemetery,	Date 20	OWN, MD. 2.	L L 3 0 Town, State
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Hanti If them 27 is marked other than "natural", so other renewalite event the Medical Examiner.		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State Cremator Evans	y or other place) Jur	ne 24,		
Page nent c		4 Donation 5 Other Specify:			1000		ll,Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. The Marked other than increase and the present than the marked other than increase.		21. Signature of Funeral Service Licenses	gan/2	Peace and Adress of Fernati 2325 York Road	yes Funer Timonium,	al&Cremat: Maryland	ign Ctr.,P.
7.2		236. Part I Enter the disease, or complica	trops that caused the death. Do not				Approximate Interval Between Onset and
Physicia Ardica		failure. List only one cause on each	ronic Alcoholism		,		Death
_xamine	er		e to (or as a consequence of):				
	И.	Sequentially list conditions, b					
		if any, leading to immediate Du	e to (or as a consequence of):				L
pk.	insit	(Disease or injury that initiated events resulting in death) Last	e to (or as a consequence of):				
60, can be executed only sician and							
), be exe	te burnal - tra	UNPENDED	AMENDED			23d. Date of deliver	\
760, ficate be		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic preg	nancy		Day Year
OX 687 eath certific	for use as the	past 12 months?	4 Pregnant at time of death 5	Other (Specify)			
Box e death c the atten	ached for	1 Yes 2 V No 9 Unknown	9 Unknown	Dort I	23e Did toba	acco use contribute to	the cause of death?
P.O. s that the	detach		ontributing to death but not resulting	in the underlying cause given in Fart i.			bably 4 Unknown
s, P.C uires that	ld be				24a. Was an	24b. Were a	utopsy findings available
Records, The law requir	shou				autopsy perform	ed? death?	
Rec The Ig	page ;			CODI CONTROL C	1 ✓ Yes 2	No 1 🗸	es 2 No
tal Rec itan: The	ector,	25. Was case referred to medical	spital:	26.Place of Death (Che tpatient 3 DOA Other Nur		esidence 6 🗸 Oth	er: Scene
FVII Physic r this		1 Ves 2 No 27. Manner of Death	I Inpationt 2	ime of Injury 28c. Injury at Work?		w injury occurred	
n of ding Pl a. After		1 Natural 5 Pending	(Month, Day,Year)	1 Yes 2 No			
SiO Atten	by the	2 Accident Investigation	28e Place of Injury - At home, ta	rm, street, factory, office building, etc.			Rural Route Number, City
Division of Vital real or Attending Physician: 1s after death.	filled in	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	(Specify)		or Town, Sta	ite)	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending if	>-	79a Cerillel . o	n: To the best of my knowledge, dea	th occurred at the time, date and place, a	and due to the cause	(s) and manner as st	ated.
the I	completely	one) 2 Medical Examiner:	On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date at	nd place, and due to	(ile cause(s)
Ğ ĕ ĕ ĕ	3	29b Signature and title of certifier		29c. License number		29d. Date signed (M June 24, 2008	ionin, Day, rear)
		(Van Koles	elu()	O.C.M.E.		JUNE 24, 2006	
Ç		30. Name and address of person who co	ompleted cause of death (Item 23a)	Penn Street, Baltimore, MD 2	1201		
Dec	Sta	11181 67 77 /1817		gorde			

ORIGINAL

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 12:52 AM June 24, Joseph Periz 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Holy Cross Hospital Montgomery Silver Spring Date of Birth (Month, Day, Year) 04/02/1937 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 □ F Months Days Hours Min 71 Bangladesh 217-49-3020 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20903-Bangladesh 148 F Colony Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify. Specify: 3 Widowed 4 Divorced Asian Indian 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) **Private Sector** Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Periz Gulapy Periz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Costa/Wife 148 F Colony Rd. Silver Spring, MD 20903-Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

þ

Completed

Be

2

Funeral

Director

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examiner must be ristified at agree.

burial-transit

and attending pt I for use as th signed by the a page To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	1 2 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	I Removal from State (y) Gat	e of Hea	aven Cemetery	2008	Silver Sp	ring, Marylan
	21. Signature of Funeral Service Licer	Moo382		and Address of Facility Funeral & Cre Gist Ave. Sil	mation Se ver Sprin	rvices g, Maryland	20910-
	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death. It one cause on each line.	-	ode of dying, such as cardiad	or respiratory and	rest,	Approximate Interval Between Onset and Death
Physician/Medical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ce f): Ce of):	sistant Pre	unonic	9	1 (
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3 Ectopie	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
ted by PI	Part II. Other significant conditions of	contributing to death but not resulting to Alessaure U	, ,	g cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death? robably 4 \(\subseteq \text{Unknown} \)
Completed by					24a. Was a autops perfor 1 □ Yes	sy prior to med? death?	utopsy findings available completion of cause of s 2 140
Be	25. Was case referred to medical examiner?				ath (Check only or	ne)	
0	1 ☐ Yes 2 KNo	Hospital: 1 ☑ Inpatient 2 ☐ ER	Outpatient 3 ☐	DOA Other: 4 Nursing H	lome 5 ☐ Resid	ence 6 Other (Spe	ecify)
ation:	27. Manner of Death 1 💆 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred	
edical Certification:	3 ☐ Suicide 6 ☐ Could not be determined		, farm, street, facto	ory, office	28f. Location (S City or Tow	treet and Number or R n, State)	lural Route Number,
edical	29a. Certifier (Check only one) 1 Sertifying Ph 2 Medical Exam	nysician: To the best of my knowle miner: On the basis of examination and manner stated.	dge, death occurr and/or investigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the durred at the time, o	cause(s) and manner a date and place, and du	as stated. e to the cause(s)
ž	29b. Signature and title of certifier		2	9c. License number	2	29d. Date signed (Mon	th, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

BARBARA

31. Date filed (Month, Day, Year)

JUN 2 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

82. Registrar's Signature

SUPANICH

00065485 06/25/2008

1500 FOREST GLEN DR. SILVER SPRING

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04774 State of Maryland / Department of Health and Mental Hygiene 2008 20917 Carol Lynn Price Certificate of Death Reg. No 1- For State 2. Date of Death 1. Decedent's Name (First, Middle,Last) 2335 hrs Month June 20, 2008 Physician/ PRICE CAROL LYNN Examiner Me/ 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Calvert Prince Frederick Calvert Memorial Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. PA 04-16-1956 52 1 M 2 X F Director 173-52-7644 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b County 1 X Yes 2 No Clinton Prince George's 28a-f show 23a or 28a-f shonotified at once. 10g. Citizen of What Country Director 10f. Zip Code 10e. Street and Number 20735 9002 Hardesty Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. White, etc. 11 Marital Status Armed Forces? 1 Never Married 2 X Married 2 X No Yes **Black** Specify: 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; o injury or other traumatic event, the Medical Examiner is 3 Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done \$ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Private Child Care Director 21215-0036 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys Hickman Be Nathaniel Suber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ္ MD Clinton, 9002 Hardest Drive Anthony R. Price / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Clinton, MD 06-26-2008 Resurrection Cemetery Donation 5 Other Specify: 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD ature of Huneral Se vice Licensee 20746 SUITLAND, MD 4308 SUITLAND ROAD Donald R. Gray 264. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and vysician Death failure. List only one cause on each line. Alcohol and cocaine intoxication complicated by ledical Immediate Cause (Final disease xamine Due to (or as a consequence of): drowning or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical 259,27,28a-f per ME, G881 7/8/08 TT X UNPENDED tending physician are use as the burial -23d. Date of delivery Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 3 Ectopic pregnancy 3b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? signed by the a contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 V Unknown ğ 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of certificate has been sector, page 2 should autopsy death? performed? 1 🗸 Yes Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Other₄ Other: Be Nursing Home 5 Residence 6 lospital: 1 Inpatient 2 ✓ ER/Outpatient 3 2 No 28d. Describe how injury occurred this 1 V Yes ို 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After Yes 2 X No Certification: unk 1 Natural 10:33 pm 5 Pending 6/20/08 28f. Location (Street and Number or Rural Route Number, City Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 (Specify) in ground pool or Town, State) 4231 Landing Lane Could not be 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: All completely filled in by the fun

> 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD.

29b. Signature and title of certifier

Medical

State Registrar

111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner 22. Registrar's Signature 31. Date filed (Mohy) Day, Year 2008

and manner stated

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

OCME

June 21, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland / Department of Health and Mental Hygiene 29d per dr., 8880, 06/27/08dhb
Registrar amend #8 Per FH G881 7/07/08 JH
Registrar amend #8 Per FH G881 7/07/08 JH Reg. No. 2008 20918 Middle, Last) Russell 1. Decedent's Name (First, 2. Date of Death Year 7008 Month Joan Day **Physician** IMG /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Season's Hospice Randallstown Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace Country) ate or Foreign **Funeral** Months Days 1 □ M 💥 F 71 213-34-0692 Director 11/28/1936 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show up or other traumatic event, Its Notice Exemple 1 array or other traumatic event, Its Notice Exemple 1. 1 ☐ Yes 2 ▼No Funeral Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 3001 New York Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Baltimore, Maryland 21215-0036 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Assembly Worker Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Russell Elizabeth Robinson မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 New York Ave., Baltimore MD 21227

Part Disnosition (Name of Date 200. Location - City or Town, State Gloria Conrades - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department o Important: If any injury or once. Burial 2 Cremation 3 Removal from State Mt. Mlivet Cemetery Baltimore, MD 4 □ Donaffen (5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. neral Service Licensee 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) END STAGE CHILDIVIC OBSTRUCTIVE FULMONMY DISDIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) this certificate has been signed by the areal director, page 2 should be detached 1 □Yes 2 12 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown SETZURE DISORDIA 24b. Were autopsy findings available prior to completion of cause of death? Multiple DECU 24a. Was an autopsy perforn Failure 10 2 1 No 1 □ Yes hin 24 hours after death.

the Funeral Director: After this certific

mpletely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) SEASONS 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Mooth/18/2008 29b. Signature and title of certifie 29c. License number 1445931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Morco Deburah 31. Date filed (Month, Day, JUN 2 7 32. Registrar's Signature State Every ! Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 20919 Certificate of Death 1. Decedent's Name (First, Middle, Last) FRANCIS 2. Date of Death Day Month Year H . RITTER **Physician** 1:09 PM 2008 26) une /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A UNION MEMORIAL HOSPITAL BALTIMORE If Under 24 Hrs. Hours Min. 8. Date of Birth 12-19-1944 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year Social Security Number 6. Sex **Funeral** 1**√** M 2□ F Months Days MARYLAND 63 Yrs 213-46-0139 **Director** Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1x Yes 2□No Director CLIFTON N/AMD or than "natural", or items 23a or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3638 ELMORA AVENUE 21213 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo IfYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ARMCO STEEL CORP. Elementary/Secondary (0-12) College (1-4or 5+) CRANE OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be FRANK **GEORGE** RITTER MARY ELIZABETH (GRAY) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BARBARA AMES/SISTER ROSEDALE, MD 2303 HOLYOKE ROAD 21237 e artment of Health a moortant: If item 27 is ny Injury or other tra 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY REDEEMER CEM 6-30-2008 BALTIMORE, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21237 CHESACO AVE ROSEDALE, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician vocardia /Medical Due to (or as a consequence of): Examiner ardiogenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) P.0. ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 XYes 2 No 3 Probably 4 Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 🗖 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by after 4 - Homicide within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 26, 2008 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital, MD Azab M.D. Raymond 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

APRIL 117 # DerFH 880 6.27 / 8 W State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month ma 300 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner enisis Dna If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 15 M 2 K F 215-10-2158 Director marylance Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It e Madfest Examiner must be notified at 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Jujury or other traumatic event, Ire Medical Examinational Lean once. 2123 9832 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: þ 3 ₺ Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Keads 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blockmon Baltimore 21206 3808 . Overlea MD W 1-lye <u>Jarlene</u> -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Dianey Valley
Hemorial Gardens 6-27-08 Timonium, P

22. Name and Address of Facility
Loans Funeral Chapel + Cremation Services 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses MD 21234 8800 Harford Rd Parkville 0 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CEREBROVASCULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of) physician s the burial Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Vear Day 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? , page 2 Hospital or Attending Physician: The 1 ☐ Yes : After this certifica e funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00053150 JUNE 25 2008 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUPTA 9650 SANTIAGO RD SUITE 110 SHALLINMALA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 20921 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav 9:08PM Bernadine Marie Symon 2008 Tune 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Months Days Hours Min. 1 □ M 2 1 F 185-14-8407 85 Aug. 15, 1922 PAUsual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8810 Walther Blvd USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2 ☑ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **1**2 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Magdaline Bodenschotz Julius A. Rosage 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7942 Belridge Road Apt. D Baltimore, MD 21236 Lance Symon / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Grandview 20a. Method of Disposition 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-24-08 Johnstown, PA 4 ☐ Dopetion 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Francis G. Ozog Funeral Home, Inc 21. Signature of Funeral Service License 710 Broad St., Johnstown, PA Munn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease Unknown Coronary disease or condition resulting in death) Due to (or as a consequence of) fibrillation Atnal Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mod 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 □ Yes 2 🗗 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∭ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

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Funeral

Director

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Important: If item 27 is
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72 hours after

Baltimore, Maryland 21215-0036

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Division of Vital Records,

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Examiner

physician and s the burial-trans Physician/Medical attending p s been signed by the should be detached ģ Completed cate has t page 2 s director, Be Certification: To

Physician: The law requires that the death certificate be executed certificate this After thi funeral or Attending thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu hours after death.

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Medical

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical Date of Injury (Month, Day, Year) 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

AT2438946

June 19, 2008

Union memoral Hospital, Bultmare, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KhatKar Ron 31. Date filed (Month, Day, Year) JUN 2 7

32. Registrar's Signature

, M.D.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner hautimone If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Maryland **Funeral** Year) 1991 Days Months 1**∑** M 2□ F Yrs. 216-37-7830 16 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 ☑ No notified MD Director Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō be 8107 Pleasant Plains Road 21286 USA 23a 7 Is marked other than "natural", or items 23a traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: multi racial þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student Education d 2 should be filed with and Mental Hygier 7 is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marcia V. Thomas Gary A. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health a Gary A. Smith 8107 Pleasant Plains Road; Towson, MD 21286 father permit. Pages 1 ar. Department of Heal Important: If Item 2 any injury or other? injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 5/Other (Specify) Moreland Memorial Park 6/28/08 Parkville, MD 4 ☐ Donation 21. Signature of Fundral Privice Dicerce 22. Name and Address of Facility 1050 York Road ett Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last dislocation The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed To the Hospital or Attending Physician: "within 24 hours after death."

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?

178 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Inpatient 2X ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 Delatural 8:05 PM 1 ☐ Yes 2 No 6/22/08 STIUCK Accident redestrian completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Loch Raven Byen + Taylor Ave Tu 3 Suicide At home, farm, street, factory, office 28e. Place of injury building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kebecea ontad 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

			1 _ State	•	epartment of H C <i>ertificate of</i>			ene _{J-No.} 2008	3 20923
			Registrar 1. Decedent's Name (First, Middle, Last)	-	Jerimoate or	Douth	2. Date of Death		3. Time of Death
	Physicia /Medic		Angela S	challer			June 26	, 2008 Year	3:00 P ^M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death		4c. County of Death	
			Augsburg Lutheran Home	An land bludle	Wood	lawn If Under 24 Hrs.	9 Data of Birth	Baltim	
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 □ M 2 □ F 7. Age	e (In yrs. last birth	Months Days	Hours Min.	8. Date of Birth (Month, Day,) Aug. 31,	1923 Pen	place (State or Foreign Intry) nsylvania
	70		Usual Residence of Decedent				nug. or,	1525 1011	
	arylan show	_	10a. State 10b. County	10c. City, Town of					10d. Inside City Limits 1 ☐ Yes 2 XNo
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	death	Funeral	12 Was Decedent F	Ever in U.S.	13. Was Decedent of H		pecify Yes or No-	14. Race - Amer Black, White	
36	filed within 72 hours after death with the Maryland Hygene. other than "natural", or items 23a or 28a-f show ent, it is Mydical Examination in difficulation.		Armed Forces? 1 Never Married 2 Married 1 Yes 2 X N If Yes, Give	lo	1 ☐ Yes 2 ☐ (No		Alcan, etc.)	Specify:	
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and	be file	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma		
ryla	hould d Mer marke	ှ	John Gekosky 19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street		tephanie		zewska
Maryland	nd 2 s lith an 27 Is I	Ì	Louis J. Schaller Son	- 1	4 N. 2nd S				vania 17349
re,	s 1 ar	1	20a. Method of Disposition		Disposition (Name of crematory or other pla			Oc. Location - City or T	
altimore,	Page ment ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Service Co	orp. 6-27			Maryland
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene Hygiene. Instruction if item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Marical Examination and interest once.		21. Sign lury of Fune of Service Lichnsee		22. Name and Addre	ess of Facility Rue Road	ck Towson Towson.	Funeral H Maryland 2	ome, Inc. 1204
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Box 6	leath certifi attending I for use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome					23d. Date of deli	very
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<u>Ч</u>	at the de	Phys	9 ☐ Unknown				00 8:111		41-4-4-0
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202	w require been significations should be	etec	7,1,900				24a. Was an		topsy findings available
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S	Attendideath ctor; /	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury	ırv - At home, farn	M 1 ☐ n, street, factory, office	Yes 2□No	28f. Location (Stre	eet and Number or Ru	ral Route Number.
2	al or / s after il Dire	Certification: To	4 Homicide determined building, etc	:. (Specify)			City or Town,		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of and manner sta	examination and					
	To the vithin compl	Me	29b. Signature and title of certifier		29c. Licens	se number	29	d. Date signed (Month	, Day, Year)
			Tasnew Yalkar	ii	D&	18595		6/20/0	F-
	5		30. Name and address of person who completed cause of de	eath (Item 23a) (T	ype, Print)	CHITT	203 /	3 127 11	D 21219
	Sta	e	31: Date filed (Month, Day, Year) 32. Registra	ar's Signature	WITH AVE,	20116	-03, 10	UNICIO IVI	0 34-6)
	Registr		111N 2 7 2008 Like	Si Age	was				

State of Maryland / Department of Health and Mental Hygiene 2008 20924 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 6:50 A^M Ethe1 Bluefarb Stone June 25, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Nursing Home Rockville Montgomery Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) October 2, 1915 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Months Days Hours Min. 1 ☐ M 2 💢 F 432-78-4414 92 Illinois Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 X Yes 2 □ No Examiner must be notified Director Rockville Marvland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 303 Adclare Road United States natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White <u>چ</u> 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Bookkeeper 12 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bluefarb Solomon Paula Brown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Suzanne Stone / Daughter 10667 Montrose Avenue, #204, Bethesda, Maryland 20814 20a. Method of Disposition
1 Bunal 2 □ Cremation 3 □ Removal from State June Date 27, 20c. Location - City or Town, State Arlington Heights, Shalom Memorial Park 2008 4 □ Donation 5 □ Other (Specify) Illinois Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licenses Physlette M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Disease Corunery Artery Physician /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an 2 1 No 1∐ Yes the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certifies 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 □ DOA ဥ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MIS D0064624 Jone 25,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Summer Walk Dr. Gaithersburg, MD 20878 SHARMA, MU 743 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of	Maryland / De <i>C</i>	partmer <i>ertificat</i>			nd M	ental Hy	giene Reg. No.	200	8 20	92
	Dhusisi		1. Decedent's Name (First, Middle	Last)						2. Date of D	eath Day	Year	3. Time of D	
	Physici /Medio		William	Howard		Thomas	S	r.		June	21,	2008	8:50P	M
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			Glen Burnie Heal 5. Social Security Number			Glen If Under		nie IfUnder24	4 Hrs. T	0. D. L (D)		e Arund		
	Funeral Director		217-16-9549	6. Sex. 7 1 ☑ M 2 ☐ F	'. Age (In yrs. last birthda 86 Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D April	rtn a <i>y, Year)</i> 9 10 2	2 9. Birti	nplace (State or I untry) MD	Foreign
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	how	_	10a. State 10b. County		10c. City, Town or	Location							10d. Inside City	
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_	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Evan, inc., ust be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Ford	ent Ever in U.S. 1: es?	3. Was Dece If Yes, spe	cify Cubar	n, Mexican,	Puerto P	lican, etc.)	0- 1	 Race - Amer Black, White 		
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	nospita 24 hours Funeral etely filler	ical	(Check only 2 Medical E	xaminer: On the bas	est of my knowledge, de sis of examination and/or or stated.	investigation	, in my op	inion, death	occurre	d at the time	, date and	place, and due	to the cause(s)	
1	within To the compli	Med	29b. Signature and title of certifier	word morning		290	. License	number			29d. Date	signed (Month	, Day, Year)	
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•	20		29b. Signature and title of certifier 30. Name and address of person w 31. Date filed (Month, Day, Year) JUN 2 7 20	ho completed cause	of death (Item 23a) (Type	e, Print)	9 Di	Son.	Pos	ode.	aler	Selo	10	
	Sta Registra	te ar	31. Date filed (Month, Day, Year)	08 32. Reg	gistrar's Signature	L)							4	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Elvera O. Trimble 1:30 A M June 25. 2008 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death 715 Maiden Choice Lane AptPV405 Baltimore 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) 1 M 2 K 215-12-3553 85 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane Apt PV405 21228 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 🛛 No Specify. White Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otto Obst Marguerite Kirk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Trimble, Sr. Husband 715 Maiden Choice Lane Apt PV405; Catonsville, MD 21248 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/28/2008 Woodlawn Cemetery Woodlawn, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Servi Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville. 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Month Metastanc disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

certificate be executed and burial-trar Box 68760 aftending physician asn jo Division of Vital Records, P.O. the detached þ s been signed to should be deta has certificate To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Examine Physician/Medical þ Completed Be Certification: To 2

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Pages 1 and 2 should be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any linjury or other traumatic evone.

3altimore, Maryland 21215-0036

				1 ☐ Yes 2 ☐] No 3 ☐ Probably 4 Unknowr	
				24a. Was an autopsy performed? 1 □Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	OOA Other: 4 In Nursing I	Home 5 Residence 6	☐ Other (Specify)	
7. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specif	ome, farm, street, factory)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier

cal

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number D1635 29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVE BALTIMORE AGNES 900 CATON 31. Date filed (Month, Day, Year)

State Registrar

JUN 2 7 2008



Physici	ian	Decedent's Name (First, Middle, Last)	tificate of Death	2. Date of Death Month Day Year 1616
/Medic Examir	cal	MARY ORTEGA TRAINOR 4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HOSPITAL	4b. City, Town, or Location of Death FORT WASHINGTON If Under 1 Year If Under 24 Hrs.	4c. County of Death PRINCE GEORGE S
Funeral Director		5. Social Security Number 525-64-4039 Usual Residence of Decedent 6. Sex 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) OCT 20, 1932 NM
and z should be filed within 7z hours after death with frie maryland eath and Mental Hygiene. The marked other than "natural" or items 23a or 28a-f show may it marked other than "natural" or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	1 Never Married 2 Married 3 Married 3 Married 3 Married 3 Married 4 Divorced 1 Near Potential Po	In the second s	ain Specify: White
certificate be executed to the permit ragges I and the purial region of Heat India physician and the purial region of the purial region	ical Examiner	20a. Method of Disposition 1 Burial 2 M Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. 3 gnature of Fune of State Power of Fune of Fune of State Power of Fune of Fune of State Power of Fune of State Power of Fune of State Power of Fune of State Power of Fune of State Power of Fune of Fune of State Power of Fune of State Power of Fune of State Power of Fune of State Power of Fune of State Power of Fune of Fune of	tan Crematory 06— Name and Address of Facility MAI 4308 SUITLAND RO	20-2008 Alexandria, VA RSHALL'S FUNERAL HOME OF MD AD SUITLAND, MD 20746
been signed by the attending pshould be detached for use as	by Physician/Med		Ectopic pregnancy Other (specify) derlying cause given in Part I.	23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow 24a. Was an 24b. Were autopsy findings available
pital or Attending Physician: was fare dealing and state of the state	Certification: To Be Completed	25. Was case referred to medical examiner? 1	Other: 4 Nursing H 28c. Injury at Work? M 1 Yes 2 No set, factory, office	autopsy performed? In Yes 2 No death? 1 Yes 2 No 1 Yes
o the Hospital or within 24 hours afte To the Funeral Dir completely filled in h	Medical	one) and manner stated. 29b. Signature and title of certified.	vestigation, in my opinion, death occu	29d. Date signed (Month, Day, Year)

			For	partment of Health and Mertificate of Death		ne No. 2008 20929			
	Physici		1. Decedent's Name (First, Middle, Last) JACOB GEORGE TAMSE JR		O Data of Dooth	Day Year 2008 2:00P M			
*	/Medic Examin		4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	4b. City, Town, or Location of Death FREDERICK ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death FREDERICK 9. Birthplace (State or Foreign)			
	Director		486-40-6829		(Month, Day, Ye May 14, 1	ear) Country)			
vith the Maryla or 28a-f shov be notified at	Director		lerick 10f. Zip Code 21702		1√2]Yes 2□No 10g. Citizen of What Country? United States				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		by Funeral		3. Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
		Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 Air	scedent's Usual Occupation ive kind of work done during most of work be. DO NOT use retired) Force Officer	U U	b. Kind of Business/Industry S. Military			
and	ld be filk ental Hy ked oth c even	To Be	17. Father's Name (First, Middle, Last) Jack Tamse		e (First, Middle, Mai ne Peterse	· ·			
Baltimore, Maryland sernit. Pages 1 and 2 should be file Department of Health and Mental Hy mportant: If Item 27 is marked oth any Injury or other traumatic event one.				ailing Address (Street and Number or Run B Stoneybrook Dr. Fi					
		- 4	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery, a Res t	sposition (Name of rematory or other place) 11 Gardens 22 Name and Address of Facility	e 25,	c. Location - City or Town, State			
Ba Ba	Deps Impo any I	9	10/	Resthaven Funeral S 9501 Catoctin Mtn.	Hwy. Free	derick, MD 21701			
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	o o o o	2	29b. Signature and title of certifier Dum Florin , MD	29c. License number		5612612008			
-	151		30. Name and address of person who completed cause of death (Item 23a) (Ty Florin Rusu, M.D. 400 West 7th Stro		21701				
4	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	esti.					
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the H iin 24 the F iplete	Medical	one)	Z Medical E	xaminer: On the band mann	ner stat	examinati ed.	on and/or inve	stigation, in my o	oinion, death occu	irred at the time,	date and	place, an	d due to	he cause(s)		
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Amend #2, perMD, g88 Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar amend #1 Per Phy G880 6/27/08 er Fricate of Death Reg. No. 2008 2. Date of Death 6/25/2008 1. Decedent's Name (First, Middle, Last) **Physician** 1546 Chatman Inomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ER Baltimore MI medical center mercy Prolinmor If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Security Number 9. Birthplace (State or Foreign **Funeral** Days Min. 251-26-9040 Months Hours SOUTHCAROLINA Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1√∑Yes 2 No ral", or Items 23a or 28a-f sl Examiner must be notifled MD N/A BALTIMORE Director permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If then 27 is marked other than "network" any injury or other traumating. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3908 PENHURST AVE. APT.C 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes ¾☐ No Specify. Specify: BIACK þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th CONSTRUCTION WORKER J. VENT & SCHAEFER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WHITMORE THOMAS DORA ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHATMON JUNIOR THOMAS 4009 BEDFORD RD. (son) BALTO, MD. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State OAKLAWN CEMETERY July 1,2008 BALTO,MD. Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 1412 Е PRESTON ST. BALTO, MD. 21213 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Endstage /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 Yes 2 No 3 Probably has been 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate har ral director, page or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 NER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural
2 Accident (Month, Day Year) 5 Pending n 24 hours after death.
he Funeral Director: A
pletely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Itel 23a) (Type, Print) 4 hu! 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008	2093
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		1- For State Certificate of Death Reg. No. 2000								2093	1 6				
Physicia	n/	1. Decedent's Name (First, Middle,Last)							Date of Death Month Day			3.	Time of Death	1	
ledical Examin		Eddie W. VanKirk						Ju	ine 22, 2	2008	Year		2025 hrs	┙	
Ź		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Locati						th		4c. C	ounty of D	eath			
_	Щ	University Hospital S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/)									VDD/YYYY) 9. Birthplace (State or Foreign				
Funeral Director		5. Social Security Number 219–92–0330	4	1 yrs. 1ast b 15	oirthday)	If Under 1 Year Months Days	If Under 24H Hours M			*	1	Count		1	
Director	L		1XM 2F		Yrs.		_ P	July 7, 1962				ישויי	4		
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faryland 28a-f show Lat once.	핡	10e. Street and Number				10f. Zip Code	1011101			10g. Citizer	of What				
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ith the 23a c		11, Marital Status	12. Was Decedent Eve	rin II S	13 Was	Decedent of Hispa	anic Origin? /	Specifi	Ves or No)- 14	Race - A	merica	n Indian, Black,	┥	
ath w irems ist be	Funeral		arried Armed Forces?			s, specify Cuban,				, '	White, e	, etc.			
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urs af tural	ğ	15. Decedent's Education (Spe	or Dates:	ted) 16	a. Decedent's	Usual Occupation	n (Give kind o		done	16b. Kind	d of Busin	usiness/Industry			
72 hor	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)		•	st of working life. [etired)		1					
215-0036 be filed within 72 ntal Hygiene. Red other than " ent, the Medical	Comple	12			Pror	essiona1	Boxer			Spo	ort				
5-003 led withii tygiene. other th	ठ	17. Father's Name (First, Middle,				18	3.Mother's Nar				rname)			٦	
21215-003 uld be filed withi Mental Hygiene marked other ti	å	Irvin W. Enos	OF.				Letha								
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shu matic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relations Eddie VanKirt				Address (Street eeAnn Ro							ip Code)	1	
e, MD 1 and 2 sho Health and item 27 is		<u>VanKirk</u>	7 5011	20h Plac		on (Name of ceme		Da					wn State	4	
Tore, MD 2 ages 1 and 2 shoul at of Health and N t: If item 27 is n other traumatic		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from State	crem	natory or othe	er place)	·			1		ation - City or Town, State 1timore, MD			
트립한토니		4 Donation 5 Other St	pecify:	_		rematory		/ 28,	/2008	Bo	ITCIII	ore	, MD	4	
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2	-	21. Syname and Address of Facility Charles L. Stevens Funeral Home In											.		
		23a. Part I. Enter the disease, or	complications that caused the	death Do	not enter the	1501 Eas	t fort	AV	enue,	Balt	imor	e,	MD 21230 Approximate Interval	d	
Physician /Medical		failure. List only one cause	on each line.					0 01 100	phatory ar	rost, shook	, or nour		Between Onset and Death	Į	
Examiner	ĺ	Immediate Cause (Final disease or condition resulting in death)	a. Complications of C		Wound to	the Abdome	n	_				-1		٦	
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8760, ifficate be exung physician us the burial	Med	IF FEMALE:	23c. If yes, outcome of),6/3Ø/08,V	δ			23d. Date of delivery				┨	
S87 rtifica ling p		23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnance								М	Da	y Year			
Box 687 e death certifi the attending ed for use as t	hysicia		4 Pregnant at tim	e of death	5 Oth	er (Specify)									
D. Be tr the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the contribute to t								e cause of death?	\dashv				
ires that the d signed by the	Ď	1Yes 2							es 2 1	No 3 Probably 4 ✔ Unknown					
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Orcanore	륁	autopsy performed								prior to completion of cause of					
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Physic arthis	ို	1 ✓ Yes 2 No 27, Manner of Death	Hospital: 1 Inpatient		VOutpatient b. Time of In		at Work?		ome 5	Residence		Other:		_	
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should to	삥	4 1	28a. Date of Injury (Month, Day Year) Nov 19, 2007	18	839 hrs	, , , , ,			bject sh		occurred	•			
SiO Atten deatl ector: by the	cati	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street, Street, St								(Street and	Street and Number or Rural Route Number, City				
Divi al or s after	Certification:		Id not be remined (Specify) Hospital						or Town, State) 322 S. Parrish Street, Baltimore, MD						
lospit I hour uners		298. Certified 4 Continue Bhardaine. To the heat of malescanding death accurred at the time date and alone, and due to the co												-	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certimate the buneral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	lica	one) 2 ✓ Medical Exa	miner: On the basis of examin	ation and/	or investigation	on, in my opinion,	death occurre	d at the	e time, date	e and place	, and due	to the	cause(s)		
To with	Medical	29b. Signature and title of certifie	and manner stated.			29c. License							h, Day, Year)	_	
		(huoto)	-			O.C.N	1.E.			June	23, 200	8(
Ω		30. Name and address of person	who completed cause of deat	h (Item 23	a)									-	
→			sistant Medical Examin			reet, Baltimo	re, MD 212	201							
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	4	P 31								_	
	rar	JUN 2 7 2	2008 Malestin	A State of	Gosal										

			State of Ma	ryland				d Mental Hy	giene			
			= State Registrar		Ce	rtificate of I	Death		Reg. No	200		0933
2	Physicia /Medic	_	1. Decedent's Name (First, Middle, Last) James Abbott Wrigle	∍у				2. Date of De Month June	Da	Year 2008	8 9	: 36 P _M
	Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or		eath	40	. County of Dea	ath	
	- A	H	Upper Chesapeake Medical C			Bel Air	If Under 24 H	lm 0 D-1- (15)		Harfor		
	Funeral Director		216-36-3078 ¹ ፟፟ M 2□ F		as <i>t birthday)</i> 9 Yrs.	If Under 1 Year Months Days		1rs. 8. Date of Birlin. (Month, Date of Divining Month)	y, Year	939 Ma	ountry)	te or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside	e City Limits
	Maryl f sho	tor	MD Harford	Ве	l Aiı	r					1 🗆 Y	∕es 2 X No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Ci	itizen of What C	ountry?	
	th witl	al D	1223 Marston Drive			21015			Ţ	USA		
	r dea	Funeral	11. Marital Status 12. Was Decedent E Armed Forces? 1 □ Never Married 2 ☒ Married 1 □ Yes 2 ☒ N	ver in U.	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? an, Mexican, Pa	(Specify Yes or No uerto Rican, etc.))-	14. Race - Am Black, Wh		1,
<i>o</i> Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notifled at	þ	1 ☐ Never Married 2 📉 Married 1 ☐ Yes 2 📉 No 1 ☐ Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	0		1 ☐ Yes 2X No	Specify:			Specify: W	hite	
9	72 ho natur iical I	sted	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of	working	16b. k	Kind of Busines	s/Industry	
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2	lled w Hygiel her tl	ပ္ပ	17. Father's Name (First, Middle, Last)		Comp	1001 100		Name (First, Middle	. Maide	n Surname)		
anc	d be f ental h ced of	o Be	Edmund Wrigley					Snyder	,	,		
Σ	shoul nd Me mark	2	19a. Informant's Name/Relationship (Type. Print)		19b. Maili	ing Address (Street	and Number o	r Rural Route Numl	er, City	or Town, State,	Zip Code)	
J Z	and 2 alth a 27 Is er tra		Mary L. Wrigley/ Wife		1223	Marston	n Dr.	Bel_Air	, MI	D 2101	5	
213, more,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. P Evair Char	lace of Dispo emetery cre 15 FU 0el-	osition (Name of matory or other place neral Bel Air	06,	Date /28 / 2008		_ocation - City o		
Baltio,	permit. Departm Importa any Inju		21. Signature of Funeral Service Licensee	4		2. Name and Addre Vans Fur Newport		hapel &	Cre Hi	emation	n Ser 2105	vices 0
			2. a. art1. Enter the disease, or complications that caused nock, or heart failure. List only one cause on each line	he death		_				•	Approxi	imate Between
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	/Medical		dis ase or condition resulting in death) a. Due to (or as a	consequ	uence of):						6	1
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10 7	ed ed	nine	S. uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			ine vasc	ula.	accident		01141	6	claye
Why.	xecut and al-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a	consequ	uence of):	one vese	u w	acci acci	((COPP	1	(3.1/00)
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928	tificati ig phy as the	ledi								-		
Вох	res that the death certific igned by the attending p be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome past 1 □ Live birth			□Ectopic pregnanc	,			23d. Date of d Month	elivery Day	Year
, O	ie dea the at ned fo	sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown	ime of d	eath 5	Other (specify) _				Width	Day	r ou.
() P	hat the	Phy	Part II. Other significant conditions contributing to death bu	t not resu	ulting in the u	underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the cause	of death?
James.	The law requires that the death certifite has been signed by the attending bage 2 should be detached for use as	d by						1	Yes	2 □ No 3 □	Probably 4	Unknown
	w require been sign	Completed						24a. Wa		24b. Were	autopsy findi	ngs available
17 8	The lav	dmo						— auto per 1∐ Yes	opsy formed? 2.21	prior to	o completion ? es 2 \(\square\) No	ngs available of cause of
; \ <u>re</u>	10 1	Be C	25. Was case referred to medical				26. Place of	Death (Check only			20.10	
√) <u>></u>	Physician: r this certific ral director,	To E	examiner? 1 Yes 2 No Hospital: 1 Impatier	nt 2 🗌	ER/Outpatie	ent 3□ DOA Oth	er: 4 🗆 Nursir	ng Home 5 ☐ Res	idence	6 □Other (Sp	pec <i>ify)</i>	
100	ding Physician: 1. After this certific funeral director,	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	Wor		28d. Describe	how inj	ury occurred		
Sis	Attending r death. ector: After	catio	2 Accident investigation		una farma et	M 1 ☐ treet, factory, office	Yes 2 No	004 *****	/O44 ·		Const Bouto	Alumbar
	after d after d I Direc d in by	Certification:	4 ☐ Homicide determined 23e. Place of inju- building, etc	. (Specif	y)	treet, factory, office		City or To		and Number or . ate)	nurai noute	Number,
3	Hospita 4 hours Funera tely fille	Medical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of and manner sta	examina								use(s)
(1	To the comple	Mec	29b. Signature and title of certifier			29c. Licens	se number		29d. D	ate signed (Mo	nth, Day, Ye	ar)
) F S F O		▶ Kamal Bangaria, M.	D.		Da	26561	1/	JU	ine :	26, 2	.008
	20		as at a time of manage who completed course of de	ath (Itam	1 23a) (Type	Brint\		MEDICAL	CE	MER,	BELA) ZR
	Sta	te	30. Name and address of person wild completed datase of del KAMA L BANGORFA, M-1 31. Date filed (Month, Day, Year) JUN 2 7 2008 32. Registra	r's Signa	iture	Carelle 1						
	Registr	ar	JUN 2 7 ZUUB	ک صح	2. 14							

Amend 19a Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 20934 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 10:52 PM June Leroy Walker /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner 4c. County of Death 492005 HOS PI ta If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Year) 287-38-8898 Director 65 29, July 1942 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shor Directo 1 ☐ Yes 2 X No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1622 Northgate Road 21218 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐Yes 2 🗓 No þ Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation within 72 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other the any lijury or other traumatic event, IT-21 once. Laborer City Water Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Walker, Sr. Alice Wilson 19a. Informant's Name/Relationship (Type Print)
Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ondra Lee Walker (Daughter) 1622 Northgate Rd., Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) North Lawn Cemetery 7/1/08 Canton, OH 22. Name and Address of Facility Rhoden Memorial 21. Signature of Funeral Service License 729 Cherry Avenue, NE Canton, OH 44702 Moun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician ★** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) physician Physician/Medical attending physical for use as the b yes, outcome of pregnancy
Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 1 ☐ Yes 2 ☐ No 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy After this certificate performed 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 ☐ Could not be

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. the Hospital or Attending Physician;

altimore, Maryland 21215-0036

completely filled in by the funeral director, within 24 hours a

To the Funeral L

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Indedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20935 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Preston Earl Woolford 2.50 JUNE 25 2000 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINA OF BALTIMORE HOSPITAL BALTIMORE CITY | HUnder 1 Year | If Under 24 Hrs. | 8. Date of Birth | Wonths | Days | Hours | Min. | Sept 11, Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Year) 1922 1 ₹ M 2 □ F 214-14-4620 85 **Director** Usual Residence of Decedent 10a, State 10c. City. Town or Location 23a or 28a-f show 10d. Inside City Limits event, the Medical Examiner nust be notified at Director MD 1 ☐ Yes 2 ☐ No Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6038 Oakland Mills Road 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1√JYes 2 □ No If¥es, Give Year or Dates: WWII or items, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2√ Married WooLFORD, PRESTON FARL
■ Baltimore, Maryland 21215-0036 1∐Yes 2**X** No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: and Mental Hygiene. White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Supervisor Printing permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked othe any lininy or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Woolford Laura Rites မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jane E. Woolford (Spouse) 6038 Oakland Mills Road Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State New Oakland Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6/30/2008 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, P.A. MOORY PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PSEUDOMONAL UROSEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE RENAL Sequentially list conditions, if they, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last FAILURE Examine Due to (or as a consequence of). The law requires that the death certificate be executed the burial-transit and GASTROIN TESTINM Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONMAY ARTER Y DISEASE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed CHRONIC OBSTRUCTIVE PULMONARY DISEASE status post tracheostomy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 2 **N**o 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending within 24 hours after death, To the Funeral Director: A

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 JUNE 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGROWAL BALTIMORE

State Registrar

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2008

			For State Registrar	State of Maryland	/ Department of H Certificate of		al Hygien 2008	20936
	Physici		1. Decedent's Name (First, Middle, I	WILLIS		2. Dat		3. Time of Death
1	/Medic Examin		4a. Facility Name (If not institution, g	4	4b. City, Town, o	or Location of Death	4c. County of Do	eath
	Funeral Director		5. Social Security Number 6	Sex 1 M 2 XF 7. Age (In yrs. las	st birthday) If Under 1 Year Months Days	Hours Min. 8. Dat	20-1943	Birthplace (State or Foreign Country)
	aryland show d at	Ļ	Usual Residence of Decedent 10a. State 10b. County		Town or Location			10d. Inside City Limits 1
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	r death w	Funeral Director	2746 KINSE 11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was Decedent of H	Hispanic Origin? (Specify Yean, Mexican, Puerto Rican,		merican Indian, hite, etc.
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Maryland	12 should and Men 1s marke raumatic	<u>۲</u>	JOHN MCKe	(Typ , rint)	19b. Mailing Address (Street	and Number or Rural Route	a Number, City or Town, State	a, Zip Code)
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	را		30. Name and address of person with	no completed cause of death (Item 2	23a) (Type, Print)	Ikeus A	ve Roll	21229
	Sta Registr		31. Date filed (Month, Day, (Year) JUN 2 7 2001	32. Registrar's Signatu	Angel i	y com to		

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			Decedent's Name (First, Middle, L.)	ast)				2. Date of Dea Month	ath Day	Year	3. Time of Death
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	Director		198-38-1538 Usual Residence of Decedent		62			05/0	9/1946	PA	
	/land		10a. State 10b. County		10c. City, Town or	Location		_		1	10d. Inside City Limits
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	be filed within 72 hours after death with the Maryland Hylgiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑	ever in U.S.	3. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp ian, Mexican, Puerto	Rican, etc.)	Blac	k, White,	
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	ottal c		29a. Certifier 1 Certifying	Physicien: To the best of	of my knowledge. de	eath occurred at the	time, date and place	e, and due to the	cause(s) and m	anner as	stated.
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			For State Registrar	State of Marylar		artment rtificate			nd Me			008	20938
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	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, To	own, or Lo	ocation of	Death		4c. Co	unty of Death	
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ija	Funeral	2	5. Social Security Number 6. Sex	M 2DE	last birthday) Yrs.	If Under 1 Months		f Under 2 Hours	Min.	Date of Bir (Month, Da	ay, Year)	Cour	place (State or Foreign ntry)
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and	w +		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						1	Od. Inside City Limits
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the	r 28a notif	Director	10e. Street and Number			10f. Zip 0	Code				10g. Citizer	of What Cour	ntry?
h wit	23a o st be	al D	3501 N. FOREST EDG	E ROAD		207	47				USA		
dear	ems er mu	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decede	ent of Hisp ify Cuban,	anic Orig Mexican,	in? (Spec	city Yes or No Rican, etc.))- 14.	Race - Americ Black, White,	
after	or it	by Ft	1 Never Married 2 Married	1 X Yes 2 □ No 19 If Yes, Give	69	1 ☐ Yes 2		Specify:				ecify:	1 0 0 10
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2 sho	h and Mental Hygiene. 7 is marked other than " traumatic event, the Med		19a. Informant's Name/Relationship (Type	oe. Print)							er, City or T	own, State, Zij	o Code)
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alor	al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Spec	119)					City of TC	wn, State)		
Hospit	within 24 hours "fter death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical Exami	sician: To the best of my kr ner: On the basis of examin									
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	()		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Tvpe.		4 CO C	000)		3	1-7	0 0
	D		Dona Leskuski	9200 Basil (0 La	rgo,	MD	20774		- 131	
	Sta	ate	31. Date filed (Month, Day, Year) 8	32. Registrar's Sign	nature	2							

			1- State of Maryland / Dep	artment of Health and Natificate of Death	Mental Hyg	giene 2008	20939
	Physic		Decedent's Name (First, Middle, Last)		2. Date of Dea Month		3. Time of Death
	/Medi Examir		Doris I. Gordon 4a. Facility Name (If not institution, give street and number) Keswick N/H	Williams 4b. City, Town, or Location of Death Baltimore		4c. County of Deal	8:00
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M 2 M 84 83 Yrs.	It Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day 4-11-		thplace (State or Foreign ountry) MD
	Maryland I-f ehow	tor	Usual Residence of Decedent				10d. Inside City Limits 1 X Yes 2 ☐ No
	with the	Direc	10e. Street and Number 2004 N. Wolfe Street	10f. Zip Code	1	0g. Citizen of What Co	ountry?
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Maryland 21215-0036	filed within 72 hc Hygiene. other than "natur	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade (Give life. N/A Secr	dent's Usual Occupation kind of work done during most of work DO NOT use retired) etary Clerical	king	16b. Kind of Business, Tucker	,
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ion of	ath. r: After this ie funeral di	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury			ow injury occurred	<i>319)</i>
Divis	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this cardificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, tarm, str building, etc. (Specify)	eet, factory, office	28f. Location (St. City or Town	reet and Number or Ru n, State)	ıral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invariant manner stated.	occurred at the time, date and place, restigation, in my opinion, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
)	To Toon	×	29b. Signature and title of certifier Luculum MO	29c. License number D35102	25	9d. Date signed (Monti	1, Dey, Year)
	Ì		30. Name and address of person who completed cause of death (Item 23a) (Type, LI M DON M.P. 590 NOV[h	CHAVLES STreet	BAlfir	nore ma	ryland
**	Sta Registr		31. Date tiled (Month, Day, Year) 32. Registrar's Signature	}			

State of Maryland / Department of Health and Mental Hygiene Walter Younger 2008 20940 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 21, 2008 1700 hrs **1 Examiner** Walter Henry Younger 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Prince George's Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year I If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Country) Director 1 x M 2 F Yrs June 13 1933 Virginia 228-39-7983 75 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No Washington notified at once. Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 1209 34th Street, SE 20019 **TISA** 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11 Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Black 4 X Divorced If Yes, Give Year Yes 2 X No specify: 3 Widowed Examiner 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. Pollard Construction Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2121 marked Be Lelia Crews Langhorne Younger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
245 Long Branch Court
Gretna, Virginia 24557 19a. Informant's Name/Relationship (Type, Print) item 27 is r traumat (Daughter) Robin Younger 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Fairview Baptist Church Cemetery 1 X Burial 2 Cremation 3 Removal from State Important: injury or oth 6-27-08 Gretna, Virginia **Department** Donation 5 Other Specify 22. Name and Address of Facility Miller Funeral Home 21. Signature of Funeral Service Licensee 668 Zion Road, Gretna, Virginia 24557 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval hysician^ם Between Onset and failure. List only one cause on each line. Medical Death a Hypertensive atherosclerotic cardiovascular diseaso Immediate Cause (Final disease **≟**xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical Unpended 23a,27,perME,g881 7/15/08 Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death Pregnant at time of death 5 Other (Specify) The law requires that the death 1 Yes 2 No 9 Unknown Unknown ned by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown 3 Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? this certificate has 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25 Was case referred to medical Be Hospital: 1 Inpatient Other₄ examiner? Nursing Home 5 Residence 6 2 V ER/Outpatient 3 DOA 1 V Yes No ٩ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury After 27. Manner of Death Certification: 1X Natural Yes 2 No 5 Pending Director: 2 ___ Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c.License number June 22, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD 32. Registrar's Strature 31. Date filed (Month, Day, Year) JUN 2 7 2008 State Registrar

Baltimore, Maryland 21215-0036

Division o	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the	Medical Certification:
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and 2 ealth n 27 i			n Brown/	/Wife					n_Re						MD20639
ges 1 t of H if iter or oth		20a. Method of Disp 1 X Burial 2		Removal from State	20b. F	lace of Dis emetery, c	position (Na rematory or	me of other plac	e)		Date		ocation - C	-	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			5 Other (Speci		Но		ds Ce				7/08				
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두 후 등	<u> </u>	27. Manner of Deat	h	28a. Date of Inju	ry	28b. Time	of	28c. Injur Worl		lursing Ho	ome 5 Res 28d. Describe				TY)
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al or Attendii after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined		ury - At ho c. <i>(Sp</i> ec <i>if</i> y	ome, farm, s	street, factor	y, office				(Street al own, State		or Rur	al Route Number,
pital Durs a leral I		29a, Certifier	158 Certifying Pl	hysician: To the best	of my kno	wledge, de	ath occurred	at the tir	ne date a	and place	and due to the	e cause(s	and man	ner as	stated
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one)		miner: On the basis of and manner sta	fexamina										
Vithin comp	Me	29b. Signature and	tille of certifier	0			29	c. License	e number			29d. Da	ate signed	(Month	, Day, Year)
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v 5		30. Name and addr	ress of person who	completed cause of the completed cause of the completed cause of the complete cause of the cause of	eath (Item	23a) (Type	e, Print)	c =	FAF	DFA	LICE.	mi	70	6	18
Sta		31. Date filed (Mon.	th, Day, Year)	32. Registra	Signa	ture	A.	. 12 .)		~ [<i>2</i> 0		
Registr	ar		JUN]	0 4000	MALL	u D	150								

Amend 20b, per FD, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 6/16/08, CCHD, State of Maryland / Department of Health and Mental Hygiene 6/16/08, drw Reg. No. 2008 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death **Physician** 150U Year SRINKS 2123 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Clinton 8604 Pretoria Court 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours M 2□F Director 86 MD 213-20-1127 March 22, 1922 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Prince Georges Clinton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or Funeral 8604 Pretoria Court USA 20735 ages 1 and 2 should be filed within 72 hours after dea nt of Health and Mental Hygiene. If fem 27 Is marked other than "naturar," or items or other traumatic event, the Medical Examiner mi 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Be Completed by Specify 3X Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Cement Finisher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Herbert Brooks Jeanette Mackall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Brooks Boyd - Daughter 8604 Pretoria Court, Clinton, MD 20735 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 6/16/08 permit. Page Department o Important: If i 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory <u>Alexandria,</u> VA 21. Signature of Funeral Service License 22. Name and Address of Facility Glady a. servell Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) luonu **Physician** 2 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a consecutince of aw requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. þ been signe should be d 4 Nnknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy The perform certificate 2 No 1□ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 1 TYes 2 ER/Outpatient 3 DOA this (1 📋 Inpatient 5 Sesidence 6 Other (Specify) Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 🗌 Yes 2 🗌 No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number use of death (Item 23a) (Type, Print) DEFENSE HIGHWAY ANNAPUGANDZIYY Name and address of person who ILHAEL 31. Date filed (Month, Day, 32. Registrans Signature State JUN 2008 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylan	d / Depa <i>Cei</i>	artment of H rtificate of L	ealth and D <i>eath</i>	d Mental Hy	giene Reg. No.	2008	20943
7			Decedent's Name (First, Middle)	, Last)					2. Date of De			3. Time of Death
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	/Medic		4a. Facility Name (If not institution,			ктеу	4b. City, Town, or	Location of De			County of Death	
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-	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 H	rs. 8 Date of Bir	rth .	9. Birth	place (State or Foreign
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			Usual Residence of Decedent									
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	r 288	Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cou	intry?
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⊇	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	l by	3 Widowed 4 □ Divorced	Year or	Dates:		TE TOS EXTRO	opeany.			Specify: wh	ite
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land	≥ 5 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	Be	17. Father's Name (First, Middle, I	Last)	Diana				` <u>-</u>	•		377
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Mar	2 sh and is m raum		19a. Informant's Name/Relationsh			1	ng Address (Street a					•
	and ealth m 27	,	Cynthia M. Nor	ton, dau			Maxwell			<u>-</u> -		
6	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from	n State	riace of Dispo cemetery, crei	sition (Name of natory or other plac	e)	Date	20c. Lc	ocation - City or T	own, State
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gaitimore,	epart epart port y lnj		21. Signature of Funeral Service I	icensee	¬.		2. Name and Addres					
<u> </u>	20 = 20		William	K. C	No		325 Mt. H				, MD 207	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deatl each line.	h. Do not ent	er the mode of dyin	g, such as card	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death
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	ъ ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conseq	uence of):						
	ocute nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с								
Ď,	e exe	ñ	resulting in death) Last	Due to	o (or as a conseq	uence of):						
8/6U	icate be executed physician and s the burial-transit	dical		d					·			
٥	The law requires that the death certificate be executed tate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Mec	IF FEMALE:									
X Q Q	death certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome pf pregna birth 2 ☐ Feta	Ideath 3	Ectopic pregnancy			1	23d. Date of deliment	very Day Year
	e deg	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pre 9□Unk	gnant at time of d nown	leath 5	Other (specify)					2 4,
J.	at th	Phy			death but wat rear	ulting in the u	ndadi dag asusa siya	on in Bort I	220 Did	tohoooou	uso contributo to	the cause of death?
Ś	w requires that the de been signed by the should be detached		Part II. Other significant condition							Yes 2	/	bably 4 Unknown
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Vital Records,	law las be	Completed by						3126926	24a. vvas	vege	24b. Were aut	topsy findings available ompletion of cause of
<u>r</u>	The ate h page	Ä	Acute of	n Chro	nic Re	inal F	alune		perf 1⊟ Yes	ormed? 2 ♣ No	death?	2□ No
<u> </u>	sician: The law certificate has b irector, page 2 s	Be (25. Was case referred to medical examiner?						Death (Check only			
0	hysic his ce I dire	2	1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3□ DOA Othe	er: 4 Nursin	ng Home 5 ☐ Res	idence	6 □Other (Spec	eify)
	ng P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending		e of Injury onth, Day Year)	28b. Time o Injury	f 28c. Injun Worl	y at k?	28d. Describe	how injui	ry occurred	
DIVISION	endii ath. or: A he fu	Certification:	2 ☐ Accidentinvestig	ation				Yes 2 ☐ No				
≝	r Att er de lrect	l∰	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ined 28e. Pla	ce of injury - At ho Iding, etc. <i>(Sp</i> ec <i>it</i>	ome, farm, sti	eet, factory, office		28f. Location City or To	(Street an own, State	nd Number or Ru e)	ral Route Number,
	ital or rs aft	Cer										
	Hosp 4 hou unel	ledical	(Check only 2 Medical	Examiner: On the	basis of examina		h occurred at the tin vestigation, in my o					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, it	ledi	one)	and ma	anner stated.							
	Vitt Son	Σ	29b. Signature and title of certifier				29c. Licenso		- 9		te signed (Month	
1			rega	n.c	>4°	rano			53		6-9-	2008
			30. Name and address of person				Print) QYX	D. WF	SUR	AN	P	
Ro	0 12		000)eale			on Re	cod	Dea	6-	MD a	20757
	Sta		31. Date filed (Month, Day, Year)	1 2 2008	Registrates Signa	ature	A. a. M. o					
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			For State Registrar	State	of Marylan		artmer <i>rtifica</i> i			and M	ental			008	3 209	944
52		18	1. Decedent's Name (First, Middle	e, Last)		····					2. Date of		Day	Year	3. Time of D	eath
	Physici /Medic		Mary Etta	Dabney	Boston						Jun		10,	2008	5:55	Æ
	Examir		4a. Facility Name (If not institution	n, give street and m	umber)		4b. City	Town, or	Location o	f Death			4c. Cour	ity of Deat	h	
			Pine View Nurs					linto					Pri		eorge's	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.		Months Months	1 Year Days	If Under 2 Hours	Min.		1, Day, Y		Co.	hplace (State or I untry)	
	Director		577-46-0452 Usual Residence of Decedent			74 Yrs.					May	26,	1934	Was	hington,	DC_
	and w		10a. State 10b. County		10c. Cit	y, Town or Lo	cation								10d. Inside City	Limits
	Maryl f sho	ō	DC N	I/A	7.7	loahina	+								1 ☑ Yes 2	2□No
	the 28a- notif	rec	10e. Street and Number	I/ A	W	ashing	10f. Zi	Code				10g	. Citizen o	f What Co	untry?	
	3a or	iO E	2919 M St., S.	E.			2	0020					I	·S.		
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notitled at	Funeral Director	11. Marital Status	12. Was De	ecedent Ever in U.	.S. 13.			spanic Orig	gin? (Spe	cify Yes o	r No-	14. R	ace - Ame	rican Indian,	
٩	after or ite		1 ☐ Never Married 2 🔀 Mar	ried Armed I	2 🔀 No		n Yes,spe 1 ∐ Yes		n, mexican Specify:	i, Puerto	Hican, etc	.)		lack, White		
21215-0036	rai", c	by	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:		1 🗆 162	ZEMINO	эреспу.				Spec	oify: B1	.ack	
<u>က</u>	72 ho	Completed	15. Deceden (Specify only highe	it's Education st grade completed	d)	16a. Dece	dent's Usu kind of we	al Occupa	ation <i>luring most</i>)	t of worki	ng	16	ib. Kind of	Business/	Industry	
[2]	ithin ne. nan "	dr.	Elementary/Secondary (0-12)	College	(1-4or 5+))				a1.1	70	1	
2	led w lygie her ti		12 17. Father's Name (<i>First, Middle,</i>	Looth		Chi.	ld Ca	re	18. Mothe	r'e Nama	/Eirot Mi				elopment	
Maryland	be fi	a	•	,							,		iden Sum	arrie)		
$\frac{3}{2}$	d Mer narke	ပ	John W. Dabne 19a. Informant's Name/Relations			105 Maille		/C4 4			Valla		34 T	04-4- 7	Ti- O-d-V	
<u> </u>	d 2 st th and 7 is n traun					19b. Mailir	_								пр Соав)	
a,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Troy Boston 20a. Method of Disposition	/ Son	20b. F	6010					inton Date		207		Town, State	
Baltimore,	ages nt of : If it		1 ☐ Burial 2 X Cremation		in State	Place of Dispo cemetery, crei									,	
	ift. P.		4 □ Donation 5 □ Other (S		Che	esapeal	e Cr	emate	ry J	une	16,20	08 Fune	Relt	svill Servi	e Maryla ce,Inc.	and
g	Depermonent of the permonent of the perm		decoles:	-8/	100											
ı.	A 140		23a. Part1. Enter the disease, or	complications that	t caused the deat									n,DC	20012 Approximate	
			shock, or heart failure. List Immediate Cause (Final	only one cause or	each line.				9, 04011 000			,,	•1		Interval Betwee Onset and De	een eath
	Physician /Medical		disease or condition resulting in death)	a. Ence	phalopat	thy									Months	
	Examiner															
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	uted I Insit	ä	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events													
<u>,</u>	execting and and ial-tra	Examiner	resulting in death) Last	C. Due t	o (or as a conseq	uence of):										
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ŏ	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregna		Ectopic p	regnancy						Date of del	ivery	
u	deat e att	sicie	in the past 12 months? 1 ☐ Yes 2 🙀 No		gnant at time of d		Other (s					_	1	Month	Day Ye	ear
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	w requires that the de been signed by the should be detached	by F	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	nderlying	cause give	en in Part I.						the cause of dea	
ğ	equir en si ould l	ed										1 🗌 Yes	21 No	3 □ Pr	obably 4 □Un	nknown
ecords,	law r as be	Completed										Was an autopsy	24	b. Were au	itopsy findings av completion of cau	vailable
r	The ate h page	E O									1 Y	performe es 2	d? I No	death? 1 ☐ Yes	_	
Vital	sician: Th certificate rector, pag	Be (25. Was case referred to medica examiner?		-					of Death	(Check o					
0	Physician: r this certific ral director,	2	1 ☐ Yes 2 X No			ER/Outpatier			4 L A .Nu	rsing Hor	me 5	Residen	ce 6 □C	Other (Spe	cify)	
	D 0 0	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	ng (Mo	te of Injury onth, Day Year)	28b. Time o Injury		28c. Injury Work			28d. Desc	ribe how	injury occ	urred		
<u>s</u>	Attending r death. ector: After by the fune	cati	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be	an of injury. At h		M		Yes 2 □ I		201 1	(0)				
DIVISION	or At fiter d Direct in by	Certification:	4 ☐ Homicide determ	since Zoe. Fla	ce of injury - At he lding, etc. (Specif	ome, tarm, str fy)	eet, tacto	у, опісе			281. Locati City o	on (Stre r Town, a	et and Nui State)	mber or Ru	ıral Route Numb	er,
_	pital		29a. Certifier 12 Certifyli	ng Physician: To t	he hest of my kno	wledge deat	h occurred	at the tin	ne date an	nd place	and due to	the cau	sa(s) and	mannor oc	ctated	
	24 hc 24 hc Fun etely	edical	(Check only 2 Medical one)	Examiner: On the	basis of examina	ation and/or in	vestigatio	n, in my o	pinion, dea	th occurr	ed at the	time, date	e and plac	e, and due	e to the cause(s)	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Med	29b. Signature and title of certifie			24	29	c. License	e number			29d	. Date sig	ned (Mont	h, Day, Year)	
)	->-0		· 1/1	5		V	П	-1854	4 5			,11	ine]	2, 20	08	
•	3		30. Name and andress of person	who completed ca	use of death (Iten	n 23a) (Type.			-					, _0		
			Philip Wisotsk					7 Wal	ldorf	More	vland	204	502			
	Sta	ate	 Date filed (Month, Day, Year) 	348	Registrar's Signa	ature	suff)		euv.L	****	, ±611U					
	Regist	rar	JUN 13	ZUU8	Carrie &	K So	34	,								

DHMH 17 Rev 1/2001

Amend Item 23a per dr., 280, 06/2//08dhb

Reg. No. 20945 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2:40A. M 17 2008 Kate Mae Curran May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett County Mem'l Hospital Oakland Garrett 8. Date of Birth (Month, Day, 03/23/ If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1908 Country) Months Days Hours 1 M 200 577-38-5287 100 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 27 is marked other then "neturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Directo WV Parsons Tucker 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 507 Main St 26287 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. e filed within 72 hours after on Hygiene.
I Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Š If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Community Development Social Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental Hi I Item 27 Is marked oth r other traumatic even Be James Calvin Curran Mary Ann Sayre ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy C. Haas 16220 Oxford Ct. Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/23/08 Thomas. WV ³ 4 Donation 5 Dother (Specify) Mt. Calvary 21. Signatur of Funeral Service Lightsee Hinkle Funeral Home y scott P.O. Box 186 Davis, WV 26260 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) hours /Medical Due to (or as a consequence of) Examiner Acute Congestive Heart Failure hours Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initiated execute. Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Atherosclerotic Cardiovascular Disease years that initiated events resulting in death) Last and Due to (or as a consequence of) Records, P.O. Box 68760 attending physician Physiclan/Medical the as esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day be detached for Month 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖄 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2CXNo 1 ☐ Yes 2 X No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 X ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred of or Attending Parties death.

I Director: After it After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0023979 05/30/2008 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) 10 Robert A. Goralski, M.D. 311 N Fourth Street Oakland, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 7 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician velson 30 dan 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** oure Hospital Jegional 8. Date of Birth (Month, Day, Year) 5/30/02 Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours 2 Min Country) Hand 1 M 2□ F None Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural" or items 23a or 28ad other. 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notifled at 1 ☐ Yes 2 ☐ No Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12507 010 Fort 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: -Completed by Black 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 0 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shenelle lone t INKNOWN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Mother permit. Pages 1 and 2 Department of Health Important: If Item 27 I any injury or other tra 12507 Old Port Washington 27 Method of Disposition

| Description | Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Biological | Cut of Bio 20c. Location - City or Town, State 20a. Method of Disposition 9. 200\$ Loured Toke Zand and Address of Facility 21. Signature of Funeral Service Licensee Reg. Itospile GUID Van Laurel HD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dremate **Physician** /Medical Due to for aş a consequence of): Examiner Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? delivery After this certificate 1 ☐Yes or Attending Physician: 25. Was case referred to medical examiner? Be *aurel* Kegional 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2☑ No Certification: To nours after death.

neral Director: After this y filled in by the funeral di 28b. Time of 27. Manuer of Death 1 Natural 28a Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) HW 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar

State

29b. Signature and title of Cartifie

31. Date filed (Month, Day, Year)

7309

30. Name and add

SteA

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

tanover PKWY

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20947 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 Ronald Joseph Cameron June 12, 2155 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/27/1948 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1**X** M 2□ F Tďaho 60 519-54-1038 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Calvert Lusby 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20657 United States 627 Running Fox Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: Vietnam 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Nuclear Power Nuclear Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Melvina E. Breeden Milton J. Cameron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 627 Running Fox Road, Lusby, Maryland 20657 JoAnn C. Cameron (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 6/16/08 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute re Due to (or as a consequence of) lymp hocytic hronic Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of eause of death?
1 ☐ Yes 2 ☐ ₩0 24a, Was an autopsy performed? Yes 2 100 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence Hospital:

Physician /Medical **Examiner**

physician and s the burial-transil

as attending

nse s

for

sate has been signed by the page 2 should be detached

uneral director,

completely filled in by the

requires that the death certificate be executed

Box 68760,

Division or Vital Records, P.O.

or Attending Physician:

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

Examine

Physician/Medical

à

Completed

Be

Certification: To

Medical

Physician

/Medical

Examiner

Funeral

Director

show

ral", or items 23a or 28a-f shov Examiner must be notified at

"natural",

ortant: If item 27 Is marked other than "natu injury or other traumatic event, the Medical

2 should be finance and Mental H

Department of Health and Mental Important: If Item 27 is marked any injury or are

within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

<u>ک</u>

Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

(Check only one)

1 Inpatient 28a. Date of Injury 5 ☐ Pending investigation (Month, Day Year)

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28c. Injury at Work?

6 ☐Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

PRINCE FREDERICK

29b. Signature and title of certifier MD

29c. License number 1060390 29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSD ITAL

ADEEB JABER 00 32. Registrans Signature 31. Date filed (Month, Day, 2008

6 Could not be determined

KW 18+1 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 20948

nny vvi	illiam Di	1-	For State Of Maryland / Department of Health and Morkal Population	Reg.	No.	3. Time of Death
	hysicia	ın/ 1	. Decedent's Name (First, Middle Last)	2. Date of Death Month E June 8, 200	Day Year 8	2000 hrs
edical	Examir	1 GI 50	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	n .	4c. County of Dea	
			9506 Acorn Park Street Social Security Number		(MM/DD/YYYY) g. E	irthplace (State or
	uneral rector		219–46–8567 1 Months Days Hours Min		1Fore	ountry)Wash.,DC
	any	7	Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 No
L	f show	<u>i</u>	Maryland Prince George's Capitol Heights Capitol	Heights 10g	g. Citizen of What Co	- AL
Mary	23a or 28a-f show notified at once.	Director	9506 Acorn Park Street 20743		USA	
MD 21215-0036 (23 chart about with the Maryand	items 23a ist be notif	펻	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Status Armed Forces? 14. Was Decedent of Hispanic Origin? (Status Armed Forces?) 15. Was Decedent of Hispanic Origin? (Status Armed Forces)	Specify Yes or No- o Rican, etc.)	14. Race - Am White, etc	erican Indian, Black,
per deal	", or it		Widowed 4 Divorced If Yes, Give Year Violand 1 Yes 2 X No specify:			ack
ar ar	atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	f work done etired)	16b. Kind of Busines	ss/Industry
36	permit. Pages I and 2 stording to Figer within 12 nous of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura injury or other traumatic event, the M <u>edical Exami</u> t	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Towing Service		Private	Industry
5-0036	Hygien other	S	17. Father's Name (Filst, Middle, Last)	ne (First, Middle, M		
2121	Mental narked event,	To Be	Richard Duckett Margar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	et Hawkii r Rural Route Num	ber, City or Town, Si	ate, Zip Code)
MD	2 shou h and h 27 is r matic		Elizabeth Duckett/wife 9506 Acorn Park St.		Heights, I	MD 20743
ore, I	es I and of Healt If item her trau	li	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem 06	Date 1.02008		
Baltimore,	t. Fag tment rtant: y or ot		4 Donation 5 Other Specify: Mary Land Veterans Celli UO 21. Signature of Euneral Service Licensee 22. Name and Address of Facility	192000	Chercenna	am, riai yiand_
Bal	Depar Depar Impo Injur		Cedar Hill FH 411	1 PA Ave	. Suitlan	d,MD 20746
	ysician		23a. Part I. Enter the disease, or complications that edused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.			Between Onset and
	A dical aminer		Immediate Cause (Final disease or condition resulting in death) a. Cocaine use complicating hypertens or condition resulting in death) Due to (or as a consequence of): Cardiovascular disease	ive atner se	oscieroti	C
			Sequentially list conditions.			-
		iner	if any, leading to immediate Due to (or as a consequence of):			
	nted d ansit	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
_	e exect cian an rial - tr	dical	X UNPENDED X AMENDED 23a, PII, 27, perME, G881 7/7/08 4b, perME, 10c, perDVR, g880 6/27/08 TT IF FEMALE: 23c. If yes, outcome of pregnancy	TT		
1760	ficate b g physicather of the bu	/We	23b, Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pre-	gnancy	23d. Date of de Month	Day Year
Box 687	eath certificate be executed e attending physician and for use as the burial - transit	Physician/Medical	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
8	he deat y the at hed for	11 6	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			te to the cause of death?
P.0	s that t gned by e detac			1 Ye		Probably 4 Unknown
rds,	aw requires that the as been signed by t 2 should be detache	Completed by		24a. Was auto	psy pric	re autopsy findings available or to completion of cause of
eco	he law ite has					th? Yes 2 No
<u> </u>	ctan: The l certificate l	Be Co	25. Was case referred to medical		Residence 6	Othor: Scone
Z.	Physical r this c	0	1 V Yes 2 No	ursing Home 5 28d. Describe	how injury occurred	
<u> </u>	nding Pl th. : After	<u> </u>				
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and more and including the strength director mase 2 should be detached for use as the burial—transis.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location or Town,		or Rural Route Number, City
	Hospital	I Cer		and due to the car	use(s) and manner a	s stated.
	Fo the vithin 2 Fo the 1	Medical	(Check only one) 2 Medical Examiner: On the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of the best of my knowledge, death declared the control of the best of my knowledge, death declared the control of the best of the best of my knowledge, death declared the control of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of th	red at the time, dat	e and prace, and do	(Month, Day, Year)
		Ž) OCME.		June 9, 200	
	-		30. Name and address of person who completed cause of death (Item 23a)	MD 21201		
			Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	, WID 2 1201		
		State	31. Date filed (Month, Day, Year) 32. Registrar's Signatur			

ORIGINAL

Records, Division or Vital

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

Doce 44

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Brint) 30. Name and address of person w

Nonte D. Clan Burne, MD 21061 MD 365 bechs

32. Pegistrar's Signature JUN 1 2 2008 Clare



Registrar

Physician/		gistrar	cate of Dea	th	Reg. N	_{10.} 20	08 209 3. Time of Death
ıl Examiner	ľ	Decedent's Name (First, Middle,Last) Susan Uz DeLeon a. Facility Name (if not institution, give street and number)	4h City	Town, or Location of De	2. Date of Death Month Da June 10, 200	y Year 8 4c. County of Death	0115 hrs
	Ļ	University Hospital	Balti	mpre der 1 Year If Under 24		1M/DD/YYYY) 9. Birt	hniace (State or
rector		Social Security Number 6. Sex 7. Age (In yrs. last to 1 M 2 4 4 5 4	Yrs.		Min. Nov 21,	Foreig	
show any see.	1	sual Residence of Decedent Da. State 10b. County 10c. City, Tot Md Anne Arunde1	wn or Location Crofton	1			10d. Inside City Limits 1 Yes 2 X No
23a or 28a-f show notified at once.		De. Street and Number 908 Eastham Ct		ip Code 21114	G	Citizen of What Cour uatemala	
", or items er must be		1. Marital Status 1. Never Married 2 Married 2. Married 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 X No If Yes, Give Year or Dates:	If Yes, spen	dent of Hispanic Origin? cify Cuban, Mexican, Pu Guatema 2 No specify:	erto Rican, etc.) alan	14. Race - Ameri White, etc. White Hi Specify:	
fental Hygiene. svent, the Medical Examin De Completed by	-	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Online (1-4 or 5+) Oth	during most of w	al Occupation (Give kind forking life. DO NOT use n Helper	retired)	Restaurant	
Mental Hygien marked other c event, the M		7. Father's Name (First, Middle, Last) Agustin Uz Chic		18.Mother's N	lame (First, Middle, Maio Albertin		
1 and Mental F 27 is marked matic event, I To Be		9a. Informant's Name/Relationship (Type, Print) Prudencio Uz DeLeon(Brother)		ss (Street and Number astham Ct (e, Zip Code)
Department of Health and Me Important: If item 27 is ma injury or other traumatic eventual or the traumatic eventual eventual eventual eventual eventual eventual eventual eve	1	0a. Method of Disposition 20b. Pla X Burial 2 Cremation 3 Removal from State Cerrife Donation 5 Qther Specify:		Pal 6/	/19/2008	Oc.Location-City or Guatemala	
Departr Import injury	1	1. Signature of Funeral Pervice/Licensee	22. Name at 5801	nd Address of Facility $N_{ m Clevel}$	Mason Funer Ave Riverda	al Service 1e Md 2073	
sician edical miner		3a. Part J Enter le disease, or complications that caused the death. Diffail Je. List only one cause on each line. Immediate Carse (Final disease or condition resulting in death) a. Head and Neck Injuries Due to (or as a consequence of):	o not enter the mod	e of dying, such as cardi	iac or respiratory arrest	, shock, or heart	Approximate Interva Between Onset and Death
nsit	Xalliller	Sequentially list conditions, f any, leading to immediate auuse. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):					
an and all - tra		d. UNPENDED AMENDED					
hin 24 bours after death. the Functions are death. the Function: After this certificate has been signed by the attending physici inplietly filled in by the funeral director, page 2 should be detached for use as the burifical Certification. To Be Completed by Physician/Med		FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death	2 Fetal dea		regnancy	23d. Date of deliver Month	y Day Year
signed by the 1 be detached 1	2	Part II. Other significant conditions contributing to death but not resu	ulting in the underly	ing cause given in Part I			the cause of death?
ficate has been significate has been significate has been significate has been significant between the significant	эшыете				24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of feet of the completion of cause of the completion of
certificate rector, page	o I	25. Was case referred to medical examiner?		26.Place of Death (Cl		esidence 6 Othe	25:
eath. tor: After this the funeral di	₽┝	1 ▼ Yes 2 No 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month Day, Year) 29. 2008 29. 2008 2008	R/Outpatient 3 8b. Time of Injury 2200 hrs	DOA 28c. Injury at Work?	28d. Describe ho		
24 hours after death. Funeral Director: After tely filled in by the funeral Contification:	eninca	2 V Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road	/ Highway		or Town, Sta 1086 Route 3 N	te) orthbound, Croftor	
within 24 h To the Fun completely	<u></u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge cone) 2 Medical Examiner: On the basis of examination and	, death occurred at l/or investigation, in	the time, date and place my opinion, death occur	e, and due to the cause(rred at the time, date ar	s) and manner as stand place, and due to t	ated. he cause(s)
To	Me	29b. Signature and title of certifier Clarac Adultar		O.C.M.E.		29d. Date signed <i>(M</i> June 12, 2008	onth, Day,Year)
12	I	30. Name and address of person who completed cause of death (Item 2					
(3)		Carol Allan, MD Assistant Medical Examiner 1	11 Penn Stree	t, Baltimore, MD 2	21201		

		1- State of Maryla		artment of F rtificate of i			giene Reg. No. 200	8 20951
Physicia	an	Decedent's Name (First, Middle, Last)	LDER			2. Date of Dea Month June		3. Time of Death
/Medic		4a. Facility Name (If not institution, give street and number)	LDEK	4b. City, Town, or	r Location of Death	June	4c. County of Dea	
	A 39	Frederick Memorial Hospital		Freder	ick If Under 24 Hrs.		Frederi	
Funeral Director		5. Social Security Number 6. Sex 1 MM 2 F 7. Age (In y.	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birti (Month, Day	y, Year) C	rthplace (State or Foreign ountry)
D		Usual Residence of Decedent				Dec.	179 192# WE	
larylar show	ō		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 📉 No
the N 28a-f notifie	Director	Maryland Frederick 10e. Street and Number	Freder	10f. Zip Code			10g. Citizen of What C	ountry?
th with 23a or 1st be	al D	8105 Canterbury Drive		217	701		U.S.	Α.
215-0036 thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify:		
		15. Decedent's Education	16a. Deced	dent's Usual Occup		in a	16b. Kind of Business	
215 ithin 7 ne. nan "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. I	DO NOT use retired	during most of work d)	ring	''I	
ING 21215- be filed within 72 tta! Hygiene. dother than "na event, the Medic		17. Father's Name (First, Middle, Last)	Pr	incipal	18. Mother's Nam	a (First, Middle,	High Scho	001
yland build be i Menta! arked o	To Be	William Glen Elder			Bert:		Burwell	
aum aum	-	19a. Informant's Name/Relationship (Type. Print)	1					Zip Code) 21754
		Karen Anderson - Daughter 20a. Method of Disposition 20b	D. Place of Dispo		ich Terra	ce, Ija	amsville, N	
S 40 # 0		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	matory or other plac	ce)		ŕ	Airy, Maryland
Baltimore, permit. Pages 1 ar Department of Hea Important: if item: any injury or other		21. Signature of runeral ServiceAicenses) 22 M	Name and Addre	ss of Facility 1-Williams	s P.A.,	Funeral House	ome
Physician		23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final	eath. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar		Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death) a. Due to (or is a cons	sequence of):	11 - 1	ronifis For la	-49		Bay
Examiner	er	Sequentially list conditions,		HEEY	ren an			iveck
uted J ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e Dus	phasia	'n			1Day
O, e exect an and rial-tra		resulting in death) Last Due to (or as a cons	sequence of)	1				
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death certifi death certifi e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	elivery Day Year
<u> </u>		Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	obacco use contribute	to the cause of death?
COrdS, w requires been signs should be	ed by					1 🗆 1	Yes 2 No 3 □ I	Probably 4 Unknown
The law The has b	Completed					24a. Was autop perfo 1∐ Yes	osy prior to ormed? death?	autopsy findings available completion of cause of
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On Or Jing Phys After this (funeral dir	ion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year	ER/Outpatier 28b. Time o	f 28c. Injui	4 ∐ Nursing Ho		dence 6 □Other (Sp how injury occurred	ecify)
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - A building, etc. (Spa	t home, farm, str ecify)			28f. Location (S City or Tov	Street and Number or I wn, State)	Rural Route Number,
ne Hospita n 24 hours ne Funera bletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.						
To th within To th	ME	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
ina		•		D	43071		6-12-	08
121VA		30. Name and address of person who completed cause of death (I	gnature (Type,	i Tou	Hous	e Ave,	Fooder	nth, Day, Year) 08
Sta Registi		JUN 1 6 2008	N 40	ede				

DHMH 17 Rev 1/2001

20952

			For State State Registrar	on Maryland / Depa	tificate of Death	-				
			Decedent's Name (First, Middle, Last)		tineate of beatif	2. Date of Dea	Reg. No.	3. Time of Death		
	Physici		David Lewis Green,	Sr.		June	7, 2008	1700 M		
	/Medic Examir		4a. Facility Name (If not institution, give street and	i number)	4b. City, Town, or Location of		4c. County of Death			
1			13518 New Acadia L	ane	Upper Marlb		Prince G	eorge's		
	Funeral Director		5. Social Security Number 6. Sex 175 - 28 - 2979 12 M 2	7. Age (In yrs. last birthday) F 71 Yrs.	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Birt (Month, Da) 6 / 1 3 / 1	h y, Year) 9. Birthp Cour	place (State or Foreign ntry) PA		
	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, The Medical Evaninar must be notified at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		1	10d. Inside City Limits		
		ctor	MD Prince Georg	je's Upper M			1)(☐)Yes 2 ☐ No			
21215-0036		Funeral Director	10e. Street and Number 13518 New Acadia La		10f. Zip Code 2 0 7 7 4		10g. Citizen of What Cour			
		<u>م</u>	1 Never Married 2 Married 1 M Y	es 2 No	Was Decedent of Hispanic Origing Yes, specify Cuban, Mexican, I Pes 2 No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.		
15-0		ietec	15. Decedent's Education (Specify only highest grade complete	led) 16a. Deced	lent's Usual Occupation kind of work done during most DO NOT use retired)	of working	16b. Kind of Business/In	dustry		
12		Completed	Elementary/Secondary (0-12) College 1 2	ge (1-4or5+)	ncipal		School			
		Se C	17. Father's Name (First, Middle, Last)			's Name (First, Middle,	Maiden Surname)			
Maryland		To Be	Frank Green, Sr.		A11 f	ie Mae Se	arles			
ary			19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number	or Rural Route Numbe	er, City or Town, State, Zip	Code)		
	and and m 27		Dorothy L. Green/W		8 New Acadta					
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		20a. Method of Disposition 1 ⅓ Burial 2 □ Cremation 3 □ Removal fi 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licensee	Resurrec	tion (Name of natory or other place) tion Name and Address of Facility 500 Allentov			D Services		
	00= 8 d		23a Part Enter the disease or demplications the	ele				Approximate		
	Physician /Medical Examiner	1	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):							
ecords, P.O. Box 68760,	The law requires that the death certificate be executed tate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	c. Due to (or as a consequence of): d.						
		Physician/Medicai	in the past 12 months?		DEctopic pregnancy Other (specify)		23d. Date of deliver	ery Day Year		
		by	Part II. Other significant conditions contributing Colon Cap	to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did to	obacco use contribute to the	he cause of death? bably 4 Unknown		
α		Completed					24b. Were autoprior to codeath?	opsy findings available impletion of cause of		
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?		Other	of Death (Check only o				
of	S S 1	- To	115 5 1 NO	□ Inpatient 2 □ ER/Outpatien ate of Injury 28b. Time of	t 3 DOA 4 NUR		5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred			
On	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ition	1 □Natural 5 □ Pending 2 □Accident investigation			· I · · · · · · · · · ·	Knews			
Division		Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		edicai ((Check only 2 Medical Examiner: On the	o the best of my knowledge, death ne basis of examination and/or inv nanner stated.	occurred at the time, date and restigation, in my opinion, death	place, and due to the of occurred at the time,	cause(s) and manner as s date and place, and due to	tated. o the cause(s)		
		Me	29b. Signature and title of certifier	72 - 7	29c. License sumber 3	13/09	29d. Date signed (Month,	Day, Year)		
7	8		(Sperior 19	23/40/0	40055	111	June 17, 2	-000		
V	(3)		Spliador Sylver	cause of death (Item 23a) (Type,	- 1 11 -> 1	Claver	(y Mm	land		
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 6 2008	2. Registrar's Signature	•		., 0			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Albert Benjamin Gryskewicz, II 06/12/2008 3:15 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 320 Terrace Drive Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1X M 2 ☐ F 214-68-8646 Director 49 03/08/1959 DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2XTNo Director MD Calvert Prince Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 320 Terrace Drive 20678 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White 2 3 ☐ Widowed 4 No Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Steamfitter Local 602 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be inent of Health and Mental nt: If item 27 is marked o Albert Benjamin Gryskewicz, Sr. Susan Matisko 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Terrace Drive, Prince Frederick, MD 20678 Albert Gryskewicz, Sr/Father permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3X Removal from State St. Mary's Nativity Ce 06/18/2008 4 ☐ Donation 5 ☐ Other (Specify) Plymouth Township, PA 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licensee Lisa M. Mounts 8125 Southern Md Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MELANOMA **Physician** METASTATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-tra Due to (or as a consequence of) attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas 1□ Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA ٩ 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

after death Director: within 24 hours a To the Funeral L

dew 5

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

29c. License number D40370

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated.

MD 110 Hospital Drive, Suite 310, Prince Frederick, MD 20678 Peter L. Wisniewski,

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier

4 Homicide

32. Registrate Signature **JUN 1 6** 2008

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 **Physician** Month Richard Eugene GOWER, SR. June 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 337 Ridge Avenue Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F 70 217-32-7260 Jan. Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Washington 1X Yes 2 □ No notified Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 337 Ridge Avenue 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 TxYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No white Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. is marked other than aluminum co. steel worker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Harry Herman Gower Mary M. Montgomery ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Gower - wife 337 Ridge Avenue, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cedar Lawn Memorial June 20 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 fred 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Malicant Due to (or as a consequence of): Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner lobocco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and a betached for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perforn Congle tive Hea certificate 25. Was case referred to medical examiner? Physician: сотріете filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 0 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After Certification: ¶Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

5H-12H

31. Date filed (Month, Day, Year) State JUN 1 8 2008

STEVEN BLASH MO

324 E. ANTIETAM ST 32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUITE 203

D58810

JUNE 17

HAGERSTOW A

Registrar

State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Melvin Harris Glover 2008 Sr. June 13. 3:15A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours Months 1 XM 2 ☐ F Oct. 27, 1917 Maryland 214-01-5840 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "tedical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 24109 Woodfield Road 20882 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 **X**No 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed by 3 XWidowed 4 ☐ Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manager Floral Shop 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be t of Health and Mental Charles Harris Glover ္ရ <u>Etta Potts</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24109 Woodfield Road, Gaithersburg, Marylan te | 20c. Location - City or Town, State Carol M. Richards - Daughter _Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Important: If any injury or once. Pine Grove Cemetery June 18, 2008 Mount Airy, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signalure of Funeral Service Licens Molesworth-Williams P.A. Funeral Home 26401 Ridge Road, Damascus, Maryland Kovert 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Rospielu **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Kidney Sequentially list conditions, if a year local to train declarate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed SEPSIS physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Preumong attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 □ No Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached? 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 □ No 2VNo 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1-Natural 5 Pending investigation n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Mulemile 06/13/08 1006581 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alexander K. Mulamula M.D. 9901 Medical Center Drive, Rockville, Md. 20850 Pigistrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 6 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea, No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7, June 2008 9:45a Charlotte Grossgebauer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Household of Angels Assisted Living Crofton Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2∰F Months 201-07-9095 90 Feb. 12. 1918 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a, State or than "natural", or items 23a or 28a-f show the Wedler Examiner must be notified at 1 ☐Yes 2X No Director MD Howard Woodstock the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or items. 10801 Enfield Drive 21163 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ္ရ George Devon Jessie Burchard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Jeanne Hartnett/Friend 119 Arundel Beach Rd., Severna Park, MD June 11, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Cemetery Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility arranco & Sons, P.A. 95 Gov. Ritchie Hwy, Ignatur of Funeral Sarvice Licens Severna Park Funeral Home Severna Park, MD 21146 Approximate Interval Between Onset and Death Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List daily one cause on each line. Immediate Cause (Final diseas or condition resumg in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Vear 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown icate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Surviving Home 5 - Residence 6 - Other (Specify) Hospital: 1∐Yes 2'⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation e Hospina. n 24 hours after death. he Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature And title of certifier 29c. License number 2007 of person who completed cause of death (Item 23a) (Type, Print) Mame and address 405 31. Date filed (Month, Day, Year) State JUN 1 2 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2008 20957 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month James Edison Gamble June 2008 13:28 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital. Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1∭M 2□F 81 Yrs. Director 211-20-6943 03-26-1927 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ir then "naturel", or iteme 23s or 28s-f ehow the Medical Examinar must be notified at 10d. Inside City Limits PA Chester West Grove Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 124 Jenner's Pond Road, Apt. 1301 19390 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mentel Hygiene.
ant: If item 27 ie marked other then "naturel; or itel ury or other traumatic event, the Madical Examinal 1 MYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Consultant Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carl Gamble Ersadelle Sturgill ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Greene / Daughter 696 Strickersville Rd., Landenberg, PA 19350 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1 Depertment of F. Important: If ite any injury or ott 2005. 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 X Removal from State Evans Cremation Svc. 6-7-2008 Leola, PA 4 ☐ Donation S ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Foulk & Grieco Funeral Home, Inc 200 Rose Hill Rd., West Grove, PA 19390 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Natra /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, a.y., leading to infracdate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1. ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On me basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Crieck only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+IVA 4 Rocco Hours de Grace MD 501 Som Union Are 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 6 200B Registrar

084290

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month HODGSON 13:58 Pm HOE NIX 2008 une 4c. County of Deeth 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) HOVENTIST MONTGOMERY SHAD HOSPITAL TROVE KOCKVILLE 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days 1 XM 2□ F NONE MARYLAND Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD MONTGOMERY JAITHERSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 VALLET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NFANT NFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HODGSON DAISY MARIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print, VALLEY ROAD GAITHERSBURG, MD NAPA IFATHERS 64 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STERI CYCLE 07/07/08 21. Signeture of Funeral Service Licens 22. Name and Address of Facility SGAH, 9901 MEDICAL CENTER DRIVE, KOCKVILLE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Immaturit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 6 hours Pulmonery Due to (or as e consequence of) Part II. Other significant conditione contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Hypotensian 1 ☐ Yee 2 ☐ No Respiratory Distress Syndrome 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy 2 X No 1L Yas 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 1

Inpatient 2 □ ER/Outpatient 1 Yes 3□ DOA 27. Manner of Death 1 Naturel 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 I Medical Examiner: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 05/08 43225 061 30. Name end eddress of person who complete cause of deeth (Item 23e) (Type, Print) Grove Shady Advantist NIGHM MADHU 31. Date filed (Month, Day, Year) 32. Registrer's Signature

Registrar **DHMH 16 Rev 6/95**

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Physician

/Medical

Examiner

Director

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tem 27 is marked other than "natural", or items 23s or 25s-f show other traumetic event, the Medical Examiner must be notified at

and Mentel Hygiane.

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permit. Pege Department

Physician

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Examiner

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To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral diractor, page 2 should be detached

To the Hospital or Attendition within 24 hours after death.
To the Funeral Director: A

Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

edical Certification: To Be Completed by Physician/Medical Examiner

filed within 72 hours after death with the Meryland

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20959 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ARRET *t*awkins 06 24 2008 22:31 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SHADY GROVE ADVENTIST ROCKVILLE, MARYLAND HOSPITAL MONTGOMER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Obs.) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** NONE MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State GERMANTOWN, MARYLAND 1 Yes 2 No MONTGOMERY Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number EAGLE COURT 20874 USA Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) INFANT NFANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HAWKINS CHRISTOPHER KEBECCA MNC ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREY EAGLE COURT, GERMANTOWN, MD HAWKINS CHRISTOPHER FATHER 12610 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I Important: If Ite any injury or of 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HALL RIVER, NC 07-24-2008 TERI CYCLE 22. Name and Address of Facility 21. Signature of Funeral Service License SGAH, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD 23a. Part1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HANTA PHORIC Immediate Cause (Final disease or condition resulting in death) DYSPLASIA **Physician** /Medical Due to (or as a consequence of) Examiner HONDROPLASI if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 XNo 24a. Was an certificate has be irector, page 2 s 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Injury I hours a er death. uneral Director Af ely filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

within 24 hours a

To the Funeral D

completely filled in

State Registrar

29b. Signature and title of certifie

30. Name and ress

LAKNER, SGAH, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MO 31. Date filed (Month, Day, Year, 2008

on who completed cause of death (Item 23a) (Type, Print)

D0030660

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2008 20960 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Hall Partricia A^{M} June 8, 2008 3:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 3611 West Mulberry Street Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2**X**□ F Virginia Director Jan 4, 1939 69 219-36-3544 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 'natural", or items 23a or 28a-f shov dical Examiner must be notifled at 1 X Yes 2 ☐ No Director Baltimore Marvland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 United States 3611 West Mulberry Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or item any injury or other traumatic event, the Medical Examinaryone. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2☐ No If Yes, Give Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📆 No Specify: Specify: Black. þ 3 ☐ Widowed 4 🎽 Divorced Be Completed 16a. Decedent's Usual Occupation. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 12 years <u>Secretary</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Pollard 2 Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kiysha Jenkins - Granddaughter 10113 Scotch Hill Drive Upper Marlboro, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State June 16, 2008 Landover, MD Harmony Mem. Park 5 ☐ Other (Specify) Donation 21. Signature of Funeral Service Licen 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metustatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Effet Underlying Cause (Disease or injury that initiated events are litting in death), act Physician/Medical Examiner Due to (or as a consequence of): as the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the burlal Division or Vital Records, P.O. Box 68760. The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ZNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2∐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death. I Director: After it d in by the funera Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 □ No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 040854 6/11/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore 21202 Riseberg 32. Registrar's Signatu Place Doub 227 31. Date filed (Month, Day, Year) JUN 1. 6 2008 State

Registrar

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show idical Examiner must be notified at

Medical

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permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other two-

Director

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

attending physician certificate I

the Hospital or Attending Physician: The law requires that the death certificate be executed this Director: within 24 hours a

Division or Vital Records, P.O. Box 68760

State Registrar

Examiner Physician/Medical à 1 Yes 2 No 3 Probably 4 Unknown Completed Fibrosis 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was and autopsy performed?

Ves 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only onel and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Pri-

Year)

1 2 2008

31. Date filed (Monti

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** David L. June 9. 2008 8:15 A Hamer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing & Rehabilitation Center Columbia Howard If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min. 1 ★M 2 ☐ F Director 383-05-4430 June 12, 1911 Tennessee Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 √ Yes 2 No Director Maryland Howard Columbia 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 9522 Caboose Court 21045 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: Black þ 3 NWidowed 4 □ Divorced "natural", Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal and Mental Hygiene. filed withii Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Protection Service Officer 12 years Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Nathaniel Hamer Carrie (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Revolon M. Schmidt - Daughter 9522 Caboose Court Columbia, MD 21045 Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) Lincolp Mem. Cemetery June 16, 2008 Suitland, MD 21. Sign ture of Funeral Service Licens Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final ACCI DENT CEREBROVASCULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à DEMENTIA 1 🗌 Yes 2 No 3 Probably 4 Honknown Completed been DIABETES 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Jas page 2 s certificate 1 Yes 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Unusing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 📋 Inpatient 2 ER/Outpatient 3 DOA မ this funeral 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check one) and manner stated. the To the within: To the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person

2008

31. Date filed (Month, Day,

ompleted cause of death (Item 23a) (Type, Print)

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50060560

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Dav Physician 2008 0140 June 8, Edward Lee <u>Jones</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Cheverly If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 → M 2 □ F Yrs. Director March 13, 1957 Washington, DC 579-78-8412 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Funeral Director Maryland Prince George's Largo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or edical Examiner must be 20774 United States 10091 Campus Way South 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐Never Married 2 ☐ Married African 1 ☐ Yes 2 ▼No Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced American Il Hygiene. other than "natur rent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Automobile Detailer</u> Private <u>ll years</u> . Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laura J. Cook Eddie Jones 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura J. Jones - Mother 10091 Campus Way South Largo, MD 20774 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 13, 2008 Landover, MD Harmony Mem. Park 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Livense 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Fatal Cardiac Arrythmia /Medical Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or he a consequence of) Examiner The law requires that the death certificate be executed Coronary Artery Disease sician and s burial-tran Due to (or as a consequence of): physician Physician/Medical Severe Emphysema attending physic for use as the b 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Dav Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) I□Yes 2□No ed by the detached 9∏Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Coronary Artery Bypass 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2√ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 ☐¥inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27, Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier June 12, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive Cheverly, MD 20785 Mohammad Naficy 31. Date filed (Month, Day, Year)

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Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20964 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 11, **Physician** Gladys Jones 3:51 P 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 17, 1911 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 KF Months Days Hours Min. ^{intry)} Virginia 97 226-68-8953 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 28a-f show , Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-1 shov ther traumatic event, the Medical Examinal must be nottlind at Maryland Prince George's Adelphi 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2702 Curry Drive 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 XX ever Married 2 ☐ Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: Specify þ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert. Jones Fannie E. 2 Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie R. Grant / Friend 125 Bilbro Lane Lena, Mississippi 39094 Department of Health Important; If item 27 any injury or other trong once. 20a. Method of Disposition Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 06/16/2008 Davidsonville, Maryland Lakemont Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses George P. Kalas Funeral Home P.A. 22. Name and Address of Facility 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛂 No Day 5 Other (specify) cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2, ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2⊠No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural n 24 hours after death.

e Funeral Director: A
pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month Day, Year) 29b. Signature and title of certifier 29c. License number D45660 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) Dpinder Singh (Do are MD) 43 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

2008

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State of Maryland / Department of Health and Mental Hygiene

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Ġ	Physicia	an	1. Decedent's Name (First, Middle, Last) NEVA JEN(-115			2. Date of Death Month		Year	3. Time of Death 0 437 M
/Medical Examiner			4a. Facility Name (If not institution, give street and number	r)	4b. City, Town, or Lo		06	4c. County	of Death	/
	ac a magazine de desagne en de la	1,50	Anne Arundel Medical 5. Social Security Number 6. Sex 7. A	Center Age (In yrs. last birthday)	Annapol If Under 1 Year		8 Date of Birth	Anne		del ace (State or Foreign
	Funeral Director		577-36-4175 1 ¹ M ² / ₂ F	7 9 Yrs.		Hours Min.	8. Date of Birth (Month, Day, 12/28/	Year) 1928	Count	V A
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	with the	Ē	10e. Street and Number 1507 A Flander Lane	507 A Flander Lane 20776			10	g. Citizen of W USA		y?
	r death	nera	11. Marital Status 12. Was Deceder Armed Forces	t Ever in U.S. 13. \	L Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spec Mexican, Puerto F	cify Yes or No- Rican, etc.)		- America	
	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene the free states as a crasse-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Married 2 Married 1 Yes 2 Nover Married 2 Married 1 Yes 2 Nover Married 2 If Yes, Give Year or Dates] No :	1 □ Yes 2 🛣 No	Specify:		Specify:	Wht:	te
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718	2 should be and Mental is marked o aumatic eve	은	Robert Jenkins 19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and	ingie (City or Town.	State, Zip (Code)
N M	and 2 sealth ar		Rosa Wines/Daughter	105 H	lolly Cir	cle, Lu		ID 206		
Ore	Pages 1 nent of He ant: If iten ury or oth		20a. Method of Disposition 1 \nstyle Burial 2 \subseteq Cremation 3 \subseteq Removal from State 4 \subseteq Donation 5 \subseteq Other (Specify)	20b. Place of Dispor	sition (Name of matory or other place) Con Natic			Suitla	1	
Dallimor	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		4 □ Donation 5 □ Other (Specify) 21. Signature if Funeral Service tricer to . ,	1 /1 22	2. Name and Address	of Facility Str	icklan	d Fun	eral	Services
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	Physician İ	i i	23a. Pert1. Enter the disease, or commonations that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final							Interval Between
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):							
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Š	attendir for use	Physician/M		2 ☐ Fetal death 3 ☐	Ectopic pregnancy			23d. Date Mor	e of deliver	y Day Year
	t the de by the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	at time of death 5	Other (specify)		1			
ָר ע	The law requires that the death certif the has been signed by the attending bage 2 should be detached for use a	by		ditions contributing to death but not resulting in the underlying cause given in Part I.				Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown		
Spicora	w requ	leted					24a. Was an			sy findings available
ב ב	Physician: The law r this certificate has b ral director, page 2 sl	Completed					autopsy perform	ned2 d	rior to com eath?	pletion of cause of 2□ No
LIVESION OF VICES To the Hospital or Attending Physician:	sician: certific rector,	Be	25. Was case referred to medical examiner? Hospital: 26. Place of Death (Check only one)							
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	al or A	Certification:	dotorminod 200.1 lace of 1	njury - At home, farm, stro etc. <i>(Specify)</i>	eet, factory, office		8f. Location (Str. City or Town,		er or Hurai	Houte Number,
	To the Hospital or Attending Physician: The within 24 Hours after death. To the Funeral Director: After this certificate hi completely filled in by the funeral director, page	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	To the within To the compl	Med	29b. Signature and title of sertifier	+ 1.0	29c. License r			d. Date signed		
0	(4)		30 Name and address of persontino completed cause of death (Item 23a) (Type, Print) DEFENSE HG/HWAY ANNAPOLIS MONEY							a vus
4	Sta	to	The state of the s	TA Wy Y strar's Signature	(41 1)tf	WSE M	19/4W/40	TINA	וטידון נ	DINDUGO
	Registr		JUN 1 6 2008 Reales	& freels						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Marcella Marilyn Johnson GUNE V ∞ 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Washington 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 M M 2 F 85 071-14-0925 Jan.16,1923 New York Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🗗 No Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11114 Mapleville Rd. 21742 U.S.A12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford O. Peterson Sr. Margaret Lawson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary W. Johnson (Son) 11114 Mapleville Rd. Hagerstown, Md. 21742 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 16, Smithsburg Crematory 2008 Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 Approximate Interval Between Onset and Death 3a. Part 1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final tonite disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Md.

Director

Funeral

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Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, it is "hadical Examinat must be notified at

al Hygiene.

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Department of Important: If it any Injury or conce.

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Pages 1 and 2 should be

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Maryland 21215-0036

Baltimore,

sician and burial-transit attending physician for use as the buria ned by the atter detached for u signed by i icate has been significate page 2 should b certificate at or Attending Physician; after death. this After

law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

Examine Physician/Medical 9 Completed funeral director, Be Certification: To To the Funeral Director: completely filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 254No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5H-10 31. Date filed (Month, Day, State

Medical

Registrar

To the Hospital within 24 hours a To the Funeral I Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Year KING 0238 7)261 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Min. Months Days Hours Wash. D.C. M 2□ F 83 Director Sept 14, 1924 579=16-0748 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm M.dical Eval Fractivitist be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 ☐ No Director Calvert Chesapeake Beach MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20732 USA Funeral 7844 C Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? 1 XYes 2 ☐ No 1 XYes 2 If Yes, Give 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 📉 No Specify: \$ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Rental Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Judith C. Smith မှ Harold Sherman King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marilyn K. VanWagner (daughter) 8060 Windward Key Drive Chesapeake Bch. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parklawn Cemetery 2008 Rockville, MD 21. Signature of Fuyleral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Michael 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 4 nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of t 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 21438 June 07,2008 EXENSE HIGH WAY ANNAPOLISMOUS JRW E 31. Date filed (Month, Day, 32. Registras Signature State 2008 ▶

DHMH 17 Rev 1/2001

Registrar

Box 68760, P.O. P Division or Vital Records,

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death curtificate be executed After To the mosphers within 24 hours after death.

To the Funeral Director: Af

Registrar

30. Name Introduces of person who completed cause of death (Item 23a) (Type, Print) Donald George, M.D. 3001 Hospital Drive Cheverly, MD 20785

29b. Signature and title of certifier

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

(Check only

31. Date filed (Month, Day, Year) JUN 1 6 2008

5 | Pending

investigation

6 Could not be determined

32. Registrar's Signature

and manner stated

DHMH 17 Rev 1/2001

Medical

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

D58182

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

June 12, 2008

			For		State of N	/laryland					and Mei	ntal Hy	giene	0000		
			State Registrar				Cei	rtificate	e of l	Death			Reg. No.	2008	21	196
Г	Physici	an	Decedent's Nam	ne (First, Middle, La	Thoma:	s F I o	na					Date of De Month une	Day 5.	Year 2008	3. Time	or Death
	/Medic		4a Facility Name /	'If not institution, giv			iig_	4b. City.	Town, or	Location (une		County of Death	1657	
	Examir	er	,	morial Hospit		.,		Prince					Calv			
-	Funeral		5. Social Security N	Number 6. S	Sex 7.7	Age (In yrs. las		If Under Months		If Under Hours	24 Hrs. 8. Min.	Date of Bir (Month, Da	rth	9. Birthp	lace (State	or Foreign
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	the N 28a-f notifie	rect	10e. Street and Nu			9,,,,,,		10f. Zip	Code				10g. Citiz	en of What Cour	ntry?	
	with 3a or	٥	2436 5th S							20736			USA			
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	11. Marital Status		12. Was Deceder	nt Ever in U.S.	13.	Was Deced			gin? (Specif	y Yes or No		4. Race - Americ		
9	after or Ite		1 Never Mar	ried 2X Married	Armed Force 1 Yes 2	No		1 ☐ Yes 2		Specify:	i, Fuerto nic	an, etc.,	- 1	Black, White,	eic.	
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5-0	72 h "natu dical	Completed	(Spe	15. Decedent's E- ecify only highest gra	ducation ade completed)	13	16a. Dece (Give	dent's Usua kind of wor	al Occup	ation during mos	t of working		16b. Kin	d of Business/In	dustry	
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ary	2 shou and M is mar aumat	-	19a. Informant's N	lame/Relationship			19b. Maili	ng Address	(Street	and Numb	er or Rural F	Route Numi	ber, City or	Town, State, Zip	Code)	
	1 and 2 Health a em 27 is		Ruth Long	ı - Wife			2436	2436 5th St. , Owings, MD 20736								
Baltimore,	m O L		3.7	Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State					ne of ther plac	ce)	Dat	е	20c. Loc	. Location - City or Town, State		
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	/Medical		disease or conditi- resulting in death)	on	7:20											
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o		.: To	1 Yes 2	ath	28a. Date of I	njury 2	28b. Time o		28c. Inju				how injury	☐Other (Speci coccurred	ny)	
ion	Attending F r death. ector: After by the funer	tior	1☐Natural 2☐Accident	5 ☐ Pending investigation		Day Year)	Injury	М		rk? Yes 2. [No					
Division		Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of	injury - At hon etc. (Specify)	ne, farm, st	farm, street, factory, office 28f. Location (Street and Number of City or Town, State)					Number or Rui	al Route N	lumber,	
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	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in											se(s)				
	o the Hosp vithin 24 ho o the Fund completely f	Medical	one) 29b. Signature an	nd title of certifier	and manner	siateu.							29d. Date	d. Date signed (Month, Day, Year)		

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manai Mathur, M.D. 110 Hosp #305 Prince Frederick, MD 20678 110 Hospita 31. Date filed (Month, Day, Year) JUN 1 2 32. Registras Signature State 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Day 2008 Margaret Lehan June 11, 12:00 pM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care at Asbury Village Montgomery Gaithersburg Gar | If Under 24 Hrs. | 1 8. Date of Birth (Month, Day, Jan. 3, If Under 1 Year Birthplace (State or Foreign 1□M 21□F Months Days Hours 93 578-20-6635 1915 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Gaithersburg Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 415 Russell Avenue, #918 20877 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married 1∐Yes 2√No If Yes, Give Year or Dates: Specify Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Lyle Elizabeth Forbes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15537 Grinnell Terrace, Rockville, MD 20855 John J. Lehan, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 4 Donation 5 Dother (Specify) 2008 Metropolitan Crematory Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W, Silver Spring, MD 20901

Physician /Medical Examiner

permit. Pages 1
Department of H
Important: If Ite
any Injury or ot

Physician

Examiner

Funeral

Director

28a-f show

ral", or Items 23a or 28a-f shov Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or Items 23a or ury or other traumatic event, It w Modical Examine I must be I

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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/Medical

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neral Director: At filled in by the fur Medical Certif

To the Hospital or Attending Physiclan: The law requires that the death certificate be execute Division of Vital Records, P.O. Box 68760.

Examiner	Sequentially list cause. Enter to Cause (Disease that initiated erresulting in dea
ysician/Medical	IF FEMALE: 23b. Was dece in the pas 1 □ Yes 9 □ Unkn
leted by Ph	Part II. Other s
Ве Сотр	25. Was case examiner?
ication: To	27. Manner of I 1 X Natura 2 Accide 3 Suicide

shock, or heart failure. List or	omplications that caused the death. Do not en nly one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Interval Between Onset and Death
Immediate Cause (Final disease or condition	_a Respiratory Failur	re		Onset and Death
resulting in death)	Due to (or as a consequence of):			
Sequentially list conditions.	_{b.} End-Stage Dementia	a		
Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):			
resulting in death) Last	Due to (or as a consequence of):			
	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		☐ Ectopic pregnancy ☐ Other (<i>specify</i>)		23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death?
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?			th (Check only one)	1
1 Yes 2 K No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	nt 3 DOA Other: 4 Nursing H	ome 5 TResidence	6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending investigat	28a. Date of Injury 28b. Time o Injury tion		28d. Describe how inju	ry occurred
3 Suicide 6 Could no 4 Homicide determin		eet, factory, office	28f. Location (Street at City or Town, State	nd Number or Rural Route Number, e)
29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physiclan: To the best of my knowledge, deat kaminer: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place exestigation, in my opinion, death occu	a, and due to the cause(s arred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
29h Signature and title of certifier		29c. License number	29d Ds	ate signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

within 24 hours a

To the Funeral C

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Merlyn Vemury,

JUN 1 3 2008

31. Date filed (Month, Day, Year)

MD

Registrar's Signature

D35791

9801 Georgia Avenue, Silver Spring, MD 20902

June 12, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** O S Betty Lou Lewis 0 6 /Medical Facility Name (If not institution, give street and numb Town, or Location of Death 4c. County of Death Examiner oastal H Wicomico 5. Social Security Number 8. Pate of Birth Month, Day, Year 2/16/1939 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F 220-34-9813 69 Director MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 XNo MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10849 St. Martins Rd. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Completed by Specify: white 3 ☐ Widowed 4 ₺ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, Maryland 2121 Is marked other than College (1-4or 5+) Deli Clerk Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul A. Stephenson Marcinia Downing 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 10849 St. Martins Rd., Berlin, MD 21811 Steven Lewis / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Cemetery 6/19/2008 4 ☐ Donation 5 ☐ Other (Specify) Berlin, MD 21. Signatur of Fundal Service Lie 22. Name and Address of Facility The Burbage Funeral Home 2myse 108 William St., Berlin, MD 21811 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UNKNOWN PRIMAR **Physician** disease or condition resulting in death) 9DENO CARCINOMA /Medical Due to (or as a consequence of): Examiner ERITONEA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 ☐ Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2/2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2□■10 24a. Was an has e 2 er this certificate has autopsy 2 آي To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2月 No 19 Enpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? a ☑Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature apportile of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Box 1733 Stas Brug no 21802

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State Registrar

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JUN 16 2008

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31. Date filed (Month, Day, Year)



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Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examination must be notified at

/Medical

attending physician for use as the burial

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within 24 hours after which to the Funeral Director: After the funeral by the funeral management of the funeral management

the Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20972 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2:04 a M Mary L. Link June 2008 14. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Towson Baltimore Date of Birth 9/21/1948 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours 382-48-6931 59 Michigan Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Director Howard Md. Ellicott City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2774 Westminster Rd. 21043 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify. \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Interior Designer Decorating 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Baty ပ Audra Arends 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph E. Link Jr./ husband 2774 Westminster Rd. Ellicott City, Md. 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/14/2008 Ardent Crematory Inc. Hanover, Md. 22. Name and Address of Facility Harry H.Witzke's Family F.H.Inc. 21. Sign wire of Funeral Service Licensee MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tie. Approximate Interval Between Onset and Death Immediate Cause (Final cars disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Er let underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

harles St. for lto Md 21204 6701 N. 31. Date filed (Month, Day, strar's Signature

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year PANKATAH **Physician** BABY 02:28A M ESLIE 06 16 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY GROVE ADVENTIST HOSPITAL ROCKVILLE 7D If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days NONE 66-16-2008 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MARYLAND POTOMAC, 1 Yes 2 □ No MONTGOMERY NORTH ND Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20878 RAIRE LANDING TERRACE by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify. Specify: RLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NFANT NFANT d 2 should be filed w th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ADIKI ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) N. POTOMAG, MD OBUADEY/MOTHER ANDING 10510 IERRACE permit. Pages I an.
Department of Healt
Important: if Ikem 27.
any injury or other tra Health a OLIVIA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 Cremation
4 ☐ Donation 5 ☐ Other (5 RIVER, NC 3 Removal from State 07/16/2008 HALL TERI CYCLE 5 Other (Specify) 21. Signature of Fun ol Service Li niee 22. Name and Address of Facility SGAH, 9901 MEDICAL CENTER DR. ROCKVITIE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. EXTREME Immediate Cause (Final disease or condition resulting in death) PREMATURIT **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if they, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No certificate has b irector, page 2 s 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Other: Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 TYes this 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28d. Describe how injury occurred 28a Date of Injury 28b. Time of funeral After (Month, Day Year) Injury 5 ☐ Pending investigation 1 Yes 2 No М n 24 hours after death.

■ Funeral Director: A letely filled in by the fu 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig 00058033

K.Y

State Registrar 30. Name and address of p

31. Date filed (Month, Day, Year)

APGAR

MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850

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4,9901 ME 32. Registrar's Signature

State Registrar noth

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HS/AO /

Washington Soventist Hospital Takoma Par

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:00 PM Robert Harland Morris 2003 June /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Olney General Hospital If Under 1 Year 6. Sex 1 ☐ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 7, 1933 9. Birthplace (State or Foreign **Funeral** Washington, DC Months . Days Hours Min. 577-46-5940 75 Morris, Harland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f shore event, the Medical Examiner must be notified at 1 □Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA #831 3310 N. Leisure World Blvd., death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1000 Yes 2 ☐ No 11. Marital Status 14. Race - American Indian. within 72 hours after 1XXYes 2 If Yes, Give 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à Specify: White 3 Widowed 4 Divorced 1955-70 Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within h and Mental Hygiene. 7 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) District Manager Bell Atlantic permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other trailment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harland Ralph Morris Antoinette Fehmer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3310 N. Leisure World Blvd., #831, Silver Spring, MD Elizabeth Morris/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State June 12, 1 ☐ Burial 2 ♣ Cremation 3 🗷 Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** VenTricular tachy car dia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Encophale Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed and)ca burial-trai Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 No of Vital 1 □ Yes 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) e Hospital or Attending Pi 24 hours after death. e Funeral Director: After ti letely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Bichhum 11,2008 DXI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Philip Dinh 18101 ich huong

Registrar

31. Date filed (Month, Day, Year)

JUN

13

2008

Registrar's Signature

Certificate of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 Physician Month Maxson Ε. McCarry June 12, 9:34AM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 9/26/1921 Director Washington, DC 220-03-2830 86 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

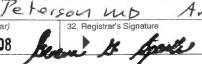
em 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or items 23a or 28a-f sl Medical Examiner must be notified 1 ☐ Yes 2 🕅 No Directo Forestville <u> Maryland | Prince George</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 USA 2908 Norman Drive by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No WWII If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carrier Foreman C&P Telephone 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward William McCarry Dorothy Louise Goodrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health an Important: If item 27 Is any Injury or other trau Helen I. McCarry/Wife 2908 Norman Dr. Forestville, Md. 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. 6/18/2008 | Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 21. Signature of Funeral Service Licensee ale 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part . Enter the diseas , or complica sho k, or heart failure. List only one ng that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician Mermonia disease or condition resulting in death) /Medical (or as a consequence of): Examiner artinsous Sequentially list conditions, if any, leading to himselfate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 💥 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Iniury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homićide To the Hospital o within 24 hours aff To the Funeral D 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

P+1

State Registrar 31. Date filed (Month, Day, Year)

JUN 1 6 2008

Robert



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

02708

Amrapeles MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year A^M III 9 2008 1:50 Burleigh Marion Odum June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-03-1939 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1∭M 2□ F Months Days Min Yrs. Wash., D.C. 68 213-38-3200 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 182 B Court 20711 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Myes 2 No If Yes, Give Year or Dates: 1957–59 1 Never Married 2 Married 1 ☐ Yes 2 No 3 ☐ Widowed 4 🏋 Divorced white Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) union plumber construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Burleigh Odum, Mary Elizabeth Boyte Marion Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Becky M. Odum, daughter 55 D Street, Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 kg Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 6/17/08 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. William 8325 Mt. Harmony LAne, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diac disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if they leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

by Funeral

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exprainer must be netitied at

3altimore, Maryland 21215-0036

attending physician and for use as the burial-transit been signed by the should be detached page 2 s

Box 68760,

P.0.

of Vital Records,

Division

Examiner Physician: The law requires that the death certificate be executed Physician/Medical Ď Completed certificate funeral director Be Medical Certification: To this ne Hospital or Attending Pl n 24 hours after death. Ie Funeral Director: After the fetely filled in by the funeral After 1

9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

ddress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

medical

29c. License number DS311

Anapolis, Md

1 ☐ Yes 2 ☐ No

0

32. Registras Signature 31. Date filed (Month, Day, Year) JUN 1 2 2008

DHMH 17 Rev 1/2001

Registrar

within 24 hou

To the Fune

completely fi

State Registra

32. Registrar's Signature

31. Date filed (Month, Day, Year) 2008

OCME

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Michael Aaron 7:12 P M Pray Sr. June 10. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LaPlata CIVISTA Medical Center Charles If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth
Feb. 6, 1946 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Nebraska Min. 1**X**M 2□ F 62 523-60-0742 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 KNo Director Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9513 Traverse Way 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Retired 126 Armed Forces Retired 176 Armed Forces Retired 176 Armed Forces Retired 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 XIIIo Specify White <u>ک</u> 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United States Air Force Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith M. Cook Walter Pray 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlina B. Pray / Wife 9513 Traverse Way Ft. Washington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 WBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cemetery 07/21/2008 Arlington, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licenses George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Clostaidium Difficile colitis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural 2 Accident (Month, Day Year) 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral E 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certific 29c. License number NOO61652 30. Name and address of person wh

Registrar
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State

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JUN 1 6

2008

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar 20980 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Evelyn Florence Poffenberger 2008 /Medical June 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ravenwood Lutheran Village Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 😾 F 88 Director Yrs. 218-01-8266 Aug. 6 1919 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23e or 28a-f show edical Experime must be notified at 1X Yes 2 □ No Maryland Washington Hagerstown Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1183 Luther Drive 21740 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Marvland 21215-0036 1 ☐ Yes 2X No Completed by Specify. 3 Widowed 4 Divorced White I've Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Public Relations Specialist Gas Company other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Clayton Poffenberger Florence Kiel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Ferguson - Niece 8613 Imagination Ct. Walkersville, Md. 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ö permit. Page Department of Important: If any injury or once. Mt. View Cemetery 6/20/08 Sharpsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Kalut Solar 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 34ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ieted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Hospital or Attending Pl 24 hours after death.
 Funeral Director: After the 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) D28365 6-18 30. Name and address of person who completed cause of de ath (Item 23a) (Type, Print) 368 1 AN 2 AN mull Street-31. Date filed (Month, Day, Year) State 2008 JUN 18 Registrar

			For State Registrar			of Ma	arylan	-	artmen			and M		Reg. No.	20	 08	2098
	Physici /Medic		1. Decedent's Name (First, M Hilda A. Pa	rrot	t								2. Date of Dea Month June	15			3. Time of Death 2:45 a M
	Examir	ner	4a. Facility Name (If not instit	Vil	la Nw	rsing	2.0		-	ator	Location of SVII	le	0. D (D.)	4c. County of Death Baltimore 9. Birthplace (State or Familia)			
30 / 20 1/2 20 / 20	Funeral Director		5. Social Security Number 215-01-0616 Usual Residence of Deceder		ex □M 2 <mark>搭</mark> 1	F /. Age	96	last birthday) Yrs.	// If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth (Month, Day, 1/1/191						year) 9. Birthplace (State or Foreign Country) Maryland		
	Maryland f show led at	or	10a. State 10b. Co					y, Town or Lo		+57						10	0d. Inside City Limits 1 ☐ Yes 2 💆 No
	or 28a-	Direct	10e. Street and Number	WOLL OF					10f. Zip	Code	42			10g. Citi	zen of Wha	Count	ry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at ance.	Completed by Funeral Director	4625 South Le 11. Marital Status 1 □ Never Married 2□ 3 Widowed 4 □ Divo	Married ced	12. Was D Armed 1 TY If Yes, Year o	Decedent Ed Forces? es 2			1□Yes 2	X No	spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)		USA 14. Race - A Black, V Specify: WI	/hite, e	etc.
215-(e. In "natu Medical	plete	(Specify only h		de complete	ed) je (1-4or 5	+)	(Give	dent's Usua kind of wor DO NOT us	rk done d	luring mos	t of workii	ng	16b. Ki	nd of Busine	ess/Ind	ustry
	illed with Hygiene ther than nt, the	Com	Elementary/Secondary (0-12yrs) 17. Father's Name (First, Michigan)			10 (1 401 0	''		Home	make 		r's Name	(First, Middle.	Maiden)wn	Home
Maryland	12 should be filed within "h and Mental Hygiene." I's marked other than "traumatic event, the Mec	To Be	• •	Hedri	ich								a Hunde				
Mar	and 2 sho ealth and n 27 is ma		19a. Informant's Name/Relation Nola P. Sha	, ,		-er							l Route Numbe Elli∞t				•
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Other	on 3 □ er (<i>Specif</i> y	Removal fr		c	Place of Dispo cemetery, crei	sition (Nan natory or o emato	ne of ther plac ry I	nc.	6/16	5/2008	20c. Lo	cation - City	or Tov	wn, State
Ball	permit Depart Import any in		21. Sign tue of Funefal Ser	vice ricen	Om!	ato	MOO										F.H.Inc. Id. 21043
	Physician and hysician and hysician phe prival-transit phe prival-transit phe prival-transit phe phe phe phe phe phe phe phe phe phe	Examiner	23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate gause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e, or comp List only o	a Due b Due	eto (or as a	a consequa	uence of):	er the mod	e of dyin	g, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pr	outcome ve birth regnant at nknown	2 ☐ Feta	Ideath 3[Ectopic pr Other (sp						23d. Date of Month		ry Day Year
	quires that n signed t uld be deta	by	Part II. Other significant cor	ditions co	_	o death bu		ulting in the u	nderlying ca	ause give	n in Part I				se contribu		e cause of death?
Vital Records,		Completed													prior	to con	osy findings available inpletion of cause of
r Vita	Physician: The this certificate har all director, page	To Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☒ No	dical	Hospital: 1	☐ inpatie	nt 2 🗍	ER/Outpatier	nt 3□DC	A Othe	ar.		(Check only one 5 ☐ Resident		3 □Other (Specify	·)
Division or	ing Ph	Certification: T	Z _ / NOOIGOIN	nding estigation uld not be	(A	ate of Injur Month, Day	Year)	28b. Time o Injury	М			No 2	28d. Describe h	now injui	y occurred		
Divi	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune		4 ☐ Homicide de	termined	bu	uilding, etc	: (Specify						City or Tow	vn, State)		Route Number,
	le Hosp 24 hou le Fune detely fil	Medical	29a. Certifier 1½ Certifier (Check only one)	ifying Phy ical Exam	niner: On th	the best on the basis of the basis of	examina	wledge, deat tion and/or in	h occurred vestigation	at the tin , in my o	ne, date ar pinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause(s date an	and manne I place, and	er as st due to	ated. the cause(s)
	withir comp	Me	29b. Signature and title of ce	rtifier	უ,	M	tw	MS	290	License	number 6 9 L	12	rsville,	29d. Da	e signed (A	onth, L	Day, Year)
	EG		30. Name and address of pe	son who d	completed of	cause of de	eath (Item	1 23a) (Type,	Print)	46	22. (aten	ystle,	~	212	28	' .
	Sta Registi		31. Date filed (Month, Day, 1)			2. Begistra		iture									

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20982 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ROOK **Physician** Month AMES 0145 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbor Health Center Anne Arundel Annapolis 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/01/1947 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Director 213-50-7050 61 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shor the Modeal Exprimer must be notified at Director 1 ☐ Yes 2 📉 No MD Tracy's Landing Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Tracy's Lane 20779 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status s filed within 72 hours after dial Hygiene. 7 I ∰Yes 2 INo If Yes, Give Year or Dates: 1969–72 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. ⋛ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) purchasing agent Office of the Architect permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philip Loring Roof, Sr. Bertha Railsback 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip L. Roof, Jr., Brother 5015 Long Cove Lane, Port Republic, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 17☐Burial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 06/17/2008 | Cheltenham, MD 21. Dignature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and De Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the the attending plant the true as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Pregnant at time of death 5 ☐ Other (specity) signed by the a ☐Yes 2☐No 9 Unknown 9 ☐ Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 this certificate 2 No 1 ☐ Yes 2 No 1 Tyes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) FERT DAGE 6 □ Other (Specify) HALBIR Hosnital: Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 290 Pate signed (Month, Day, Year) Hune 11, 2008 29b. Signature and title of certifier

dru 5+1

State Registrar 31. Date filed (Month, Day, Year) JUN 12

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Name and address of person who completed ca

32. Registra Signature

use of death (Item 23a) (Type, Print)

Print) 45 DEFENSE HIGHWAY ANNAPUL OMO

State of Maryland / Department of Health and Mental Hygiene 20983 Certificate of Death Rea. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Evelyn Theresa Rankin 7:45 PM 12 2008 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Berlin Nursing Home Worcester Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/31/1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Months Hours Min. 1 M M F 84 Director 220-14-5067 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 XNo Director MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or be ns 23a c must be 233 Windjammer Rd. 21811 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Rankin, Evelyn Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: white 3 X Widowed 4 □ Divorced Year or Dates: the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be rent of Health and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Gerda Boe Bernard Hayden ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Greenwood / daughter 324 Bayshore Dr., Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 6/14/2008 Frankford, De 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signature of une 22. Name and Address of Facility Fervice Licens The Burbage Funeral Home 23a. Part1. Enter the disease or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death Immediate Cause (Final CHIS **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buriz Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9☐Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print Coostel Highwy Fewet Ideal De 19244 1209 BA4 32 Registrar's Signature State **JUN 16** Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 4:15 June Dora King Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Sacred Heart Nursing Home Hyattsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Sept 6, Georgia 98 047-09-5505 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notifited at YYes 2 No Director Maryland Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20782 5805 Queens Chapel Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinar once. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ **Black** 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Private 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gussie Billingsley Henry King ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6010 Sargent Road #1106 Hyattsville, MD 20782 Henrietta Rogers - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Lee's Crematory June 13, 2008 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Dicensee 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. set and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's Disease Unknown **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the bunal-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy Year Month been signed by the atte should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Dementia, Poor Intake, Failure to Thrive, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Chronic Anemia 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2X No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No M ours after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Chowdle D43121 June 10, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nurul Chowdhury, M.D. 15216 Dino Drive Burtonsville, MD 20866 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 6 2008 Registrar

			1 - For State Registrar	State of Maryl	and / Depa	artment of rtificate o	Health and f Death	Re	g. No.	
	Physici /Medi		Decedent's Name (First, Middle, Las George Freder		ς			2. Date of Death Month June 1	Day 2008	3. Time of Death 8:10 A. M
	Examir		4a. Facility Name (If not institution, give				, or Location of Dea	h	4c. County of Dea	
	Funeral Director		183-01-8370		rrs. last birthday) 95 Yrs.	Rockv: If Under 1 Ye. Months Day	ar If Under 24 Hrs		Montgom 9. Bir Pen	thplace (State or Foreign ountry) nsylvania
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgon		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 28a st be notii	ai Director	10e. Street and Number 23707 Woodfield F	Road		10f. Zip Code 208	• 882		g. Citizen of What Co Jnited Sta	
980	iges 1 and 2 should be filed within 72 hours after deeth with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give WW Year or Dates WW		Was Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi Specify: Wh	te, etc.
21215-0036	e filed within 72 ho al Hygiene. I other then "natur vent, the Madical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	16a. Deced (Give life. Edit		cupation ne during most of wo ired)	rking	6b. Kind of Business J.S. Gover	
Maryland 2	ould be filed Mental Hygid arked other atic event, II	To Be C	17. Father's Name (First, Middle, Last) Charles Wharton	Stork				me (First, Middle, M h Von Pau		
	1 and 2 should Health and Men tem 27 is marke other traumatic.		19a. Informant's Name/Relationship (7) Catherine S. Water						City or Town, State, 1179, MD 208	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 20 Other (Specify,	Removal from State Me		matory or other p wn University enter	ersity Jur 20	ne 10 008	Oc. Location · City or Vashington	, D.C.
Ball	permit Depart Import any in		21. Signature of Funeral/Service Ligens	Cordn	9	013 Anna	apolis Roa	ad,Lanham,	MD 20706	vices,P.A.
**	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	floations that caused the dine cause on each line. a	NO NO		ying, such as cardia			Approximate Interval Between Onset and Death
68760,	tificate be executed g physicien and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons						
P.O. Box 68	aath cer attendin for use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnar Other (specify)			23d. Date of de Month	livery Day Year
rds, P	w requires that the de been signed by the should be detached	۵	Part II. Other significant conditions co		resulting in the ur	nderlying cause	given in Part I.	23e. Did toba	acco use contribute to s 2 No 3 □ Po	o the cause of death?
I Records,		Completed						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
Vita	nysician: Thinis certificate	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only one		
ō	Phys r this rai di	5	1 Yes 2 No	28a. Date of Injury	ER/Outpatien 28b. Time of	L SLI DOA		lome 5 Resider	nce 6 Other (Spe	ocify)
Division of	To the Hospital or Attending Physician: which 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - A	Injury t home, farm, stre		□Yes 2□No		eet and Number or R	ural Route Number.
á	spital or hours efte meral Din y filled in I		29a. Certifier Certifying Phy	building, etc. (Spe	cnowledge death	occurred at the	time, date and place	City or Town,	usa(s) and manner as	s stated.
	the Hc in 24 the Fu pletely	Medical	(Cluck unity 2 Medical Exami one)	ner: On the basis of exam and manner stated.	ination and/or inv	estigation, in my	opinion, death occi	irred at the time, da	te and place, and due	e to the cause(s)
	V September 1	2	29b. Signature and title of certifier	englo	nu nu	_	nse number 3826 2	70	d. Date signed (Mont	
100			30. Name and address of person who co		tem 23a) (Type,	Print)	h BLVI	Sute?	0850 330 Ro	challens
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State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Mary M. Solomon 2008 8:17 AM 12. June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Rockville Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) 93 yrs If Under 1 Year | if Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Funeral 209-10-9051 Months 1 □ M 2 🔀 F May 8, 1915 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XINo Maryland Montgomery Rockville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20855 United States 7220 Panorama Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 AWidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Pribelo Frank Bugden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7220 Panorama Drive, Rockville, MD 20855 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. Elsie Jean Sporer (Daughter) 20c. Location - City or Town, State Ridgway Township, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State June 17, Oakmont Cemetery 2008 4 □ Donation 5 □ Other (SpeCity) Pennsvlvania 22. Name and Address of Facility 21. Signature of Funeral Service DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 Fart1. Et e, or complications that caused the death. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cluse (Final disease or condition resulting in death) Myocardial Infarction hours **Physician** /Medical Due to (or as a consequence of): Examiner days Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physician and for use as the burial-transit days Clostridium Dificile Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Frequent Urinary Tract Infections years Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Year 5 ☐ Other (specify) 9☐Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hyperlipidemia autopsy performed' 2 No I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔀 inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertitier 29c. License number 29d. Date signed (Month. Dav. Year) 00065930 JUNE 12, 2008 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUCKNILLE MO 0 margn g 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 20987 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 10 2008 JUN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Hebrew Home of Greater Washington If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 □ F 90 Dec. 8, 1917 New York 577**-**20-6893 Usual Residence of Decedent 1∩a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland Montgomery Rockville 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 20852 U. S. A. 6121 Montrose Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Alyes 2 □ No Nav If Yes, Give Year or Dates: WW 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 2□No Navy 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Specify Specify 3 Widowed 4 Divorced WW 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Women's Clothing Manufacturers Representative 8th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Dubinsky Jacob Arskin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10207 Iron Gate Road, Potomac, Maryland Leonard A. Sloan - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Purial 2 □ Cremation 3 N Removal from State King David Mem Gdns 6/12/2008 Falls Church, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland Donald. 23a. Part1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LZH DEMENTIA Due to (or as a consequence of): Sequentially list conditions, Due to for as a consequence of cause. Einter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown ANEMIA Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an HTN 1∐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

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Completed

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Funeral

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

within 72 hours after

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permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tra

Baltimore, Maryland 21215-0036

Box 68760

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burial-transil and attending physician the use as t detached the sate has been signed by page 2 should be detach funeral director, this After Hospital or Attendii 24 hours after death. e Funeral Director: A letely filled in by the fu

23b. Was decedent pregnant

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 Natural 2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Konau, MD

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

ROCKUILLE, MD 20852

1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

ANNA KOR

57284

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6105 MONTROSE ROAT

State Régistrar 31. Date filed (Month, Day, Year) JUN 13 2008



To the Hospital of within 24 hours aft To the Funeral D completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 20988 Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 9:50 P M 11 2008 Howard T. Scheufele June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ellicott City Howard Communicare 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**∑**M 2□ F MD Director 1931 215 28 4044 76 Sept 1, Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 □Yes 2 TXNo Director Marriottsville MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Important: if item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I 21104 United States 12075 Old Frederick Road Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 X Yes 2 □ No
If Yes, Give
Year or Dates:1950-53 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mill Worker Monumental Mill Work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Be Raymond Scheufele Margaret Hook ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar 12075 Old Frederick Road Marriottsville, MD 21104 Molly Scheufele/Sister in law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Cemetery Elkridge, MD 6-17-2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses M01044 ol 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician years DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying dause (Liesause of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 No ate has been signed by the page 2 should be detached 9□Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1□ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical **SOMPletely** (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Speph MD 0005350

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State Registrar 31. Date filed (Month, Day, Year) 32. JUN 16 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suple 9650 Senhajo le Suite 110 Columbia MO 21045
32. projetrar's Signature

or Appeller

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	State of Maryland / Department of Health and Mental Hygiene

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Division tal or Attendi rs after death. al Director: A	liga		congenion			me, farm, stre	et, factory,	office bu	uilding, etc	_	28f. Location	(Stree	et and Number or		e Number, City
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36	ırs after de il", or Item xaminer π	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer Yes 200 No Specify: 	to Rican, etc.)	14. Race - Ame Black, Whit Specify:	
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2	/Medical Examiner		Due to (or as a consequence of):	oid Leukemia			8 Hears
	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	130			- years
o,	ificate be executed g physician and as the burial-transit		that initiated events c resulting in death) Last Due to (or as a consequence of):				
8760	cate be ohysicia the bu	edical	d				
). Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/Me		3 Ectopic pregnancy 5 Other (specify)		23d. Date of de Month	livery Day Year
s, P.O.	ss that th gned by be detac	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		bacco use contribute	
Records,	v requir been sig should	eted			1 🗌 Ye		robably 4 🗌 Unknown utopsy findings available
		Completed			autops perforr	sy prior to	completion of cause of
ŽĮ.	slcian; certific lirector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Othor	ath (Check only one	ence 6 🗆 Other (Spe	c(fv)
on of	Ing Phys	ion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Inju	e of 28c. Injury at		ow injury occurred	ony)
Division of Vital	To the Hospital or Attending Physician: which 24 hours after death with 24 hours after death. To the Funeral Director: After this certification in the funeral director, completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, bullding, etc. (Specify)		28f. Location (S City or Town	treet and Number or F n, State)	tural Route Number,
	Hospita 24 hours Funeral	Medical C	29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledge, do and manner stated.				
	Northin Comp	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mon	th, Day, Year)
			Keth PRATZ Medical Poc	tor Res-000	(June 10	2008
_	(10)		30. Name and address of person who completed cause of death (Item 23a) (Ty	' '	North Wol	fe St, Baltim	ore, MD, 21287
	Sta Registr	_	31. Date filed (Month, Day, Year) JUN 1 6 2008 Steven M	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., 2880, 06/27, 08dhb Reg. No. 20992 1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Warrick 5:05 AM D. 2008 Rosemary 4 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Olney Montgomery General Hospital 8. Date of Birth (Month, Day, You July 30, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** , 1931 North Carolina 1 ☐ M 2 🔀 F Months Days Hours Min. 578-44-3954 76 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It e Medical Examinar must be indiffed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director D.C. Washington Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 U.S. 4921 Minnesota Ave., N.E. Funeral 14. Race - American Indian, Black, White, etc. African—American Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Technician U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosa Fields Harvey Davis ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau Jacqueline Allen-Daughter 4921 Minnesota Ave., N.E., WDC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State June 13, 2008 Brentwood, MD Ft. Lincoln Cemetery: 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bonnette & Assoc. Funeral Home 2504 28th St., N.E., WDC 20018 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Acute Rena1 Failure **Examiner** discussion of the state of the Examiner Due to (or as a consequence of): Respiratory Failure Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Congestive Heart **Failure** Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ፩ 1 | Yes 2 No 3 | Probably 4 | Unknown мпет this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🛱 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number Doo 6 22 65 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 810

32. Registrar's Signature

adik Day, Year) 7 2008 VOID
CERTIFICATE **

2008-20993

SEE

CERTIFICATE #

08-16293

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examination to intelliged at agree. Baltimore, Maryland 21215-0036

> **Physician** /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, SX

ctor	MD.	Montgon	nery		Rocl	kv i l	.1e						1 ☐ Yes 2 🙀 No
ire	10e. Street and Nu	mber				10f. Z	ip Code				10g. Citi	zen of What Co	ountry?
<u>=</u>	5616 La	ke Christo	pher Driv	7e			2085	5			Uni	ted Sta	ates
Completed by Funeral Director	11. Marital Status 1 Never Marr 3 Widowed	ried 2X Married	12. Was Decedent Armed Forces? 1 XYes 2 1 1 If Yes, Give Year or Dates:	No		_	edent of His ecify Cubar 2 🙀 No	spanic Origin? (n, Mexican, Pue Specify:	(Specif erto Ric	y Yes or No ean, etc.)	-	14. Race - Ame Black, White Specify: Wh	te, etc.
g	3 🗆 Widowed	15. Decedent's Edu		VICU	16a. Decede	ant'e He	ual Occupa	tion			16h Ki	nd of Business	/Industry
mplet	(Spec	cify only highest grad	College (1-4or 5	+)	(Give k	ind of w O NOT i	ork done di use retired)	uring most of we	orking			dical	, maddi y
Be	17. Father's Name	(First, Middle, Last) Wehunt			Raule	<u> </u>		18. Mother's Na		First, Middle, .ns1et	Maiden		
၉		ame/Relationship (7) Wehunt (Wi			1			nd Number or F					Zip Code) ID 20855
	20a. Method of Dis		Removal from State	CE	lace of Disposi emetery, crema ropolit	ition (Na atory or	ame of other place	Jun	Date 1e 1	9		cation - City or	
		uneral Service (Specify)		1100	-			s of Facility D		1 Fun			- ,
	110,	sen/t/k	m)										MD 20877
	23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	on .	ne cause on each lii	ne.				, such as cardi					Approximate Interval Between Onset and Death
	resulting in death)		Due to (or as	a consequ	ence of):		IMAGI	MAA					
aminer	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events)	nmediate erlying injury s	Due to (or as	a consequ	ence of):	L	7 / 1 /	10/00(
dical Ex	resulting in death)	Last	Due to (or as	a consequ	ence of):						291		
Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3		pregnancy specify)					23d. Date of de Month	elivery Day Year
F		ficant conditions co	ntributing to death b	ut not resu	Iting in the und	derlying	cause give	n in Part I.		23e. Did to	obacco u	se contribute t	to the cause of death?
ed by	COLON	J CANC	ER						-	1 🗆 🤈	Yes 2[□No 3□F	Probably 4 LUnknown
complet									-	24a. Was autor perfo 1 □Yes	an osy rmed? 2 ∑ No	prior to death?	utopsy findings available completion of cause of s 2 \(\sum \) No
ge (25. Was case refer examiner?	⊢						26. Place of De	eath (C	Check only o	ne)	_	
	1 ☐ Yes 2 🔀	No	lospital: 1 💢 Inpatie	nt 2 □ l	ER/Outpatient			- I Training	Home	5 🗌 Resid	dence (6 □Other (Sp	ecify)
ation:	27. Manner of Deat 1 Natural 2 Accident	th 5 ☐ Pending investigation	28a. Date of Inju (Month, Da	ry y, Year)	28b. Time of Injury	М	28c. Injury Work? 1 □ Y	at ? ′es 2 □ No	280	f. Describe	now injur	y occurred	
ertific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubulding, etc	ury - At hor c. (Specify	me, farm, stree	et, facto	ry, office		28f.	Location (S City or Tox	Street an vn, State	d Number or Fi)	Rural Route Number,
Medical Certification: To	29a. Certifier (Check only one)	Certifying Phy 2 Medical Exami	sician: To the best Iner: On the basis o and manner sta	f examinat	vledge, death ion and/or inve	occurre	ed at the tim	e, date and pla pinion, death oc	curred	d due to the at the time,	cause(s)) and manner a I place, and du	as stated. e to the cause(s)
Z	29b. Signature and	title of Certifier				29	9c. License	number			29d. Dat	e signed (Mon	th, Day, Year)
	1.0	Uniz					D26	- 11					2008
	30. Name and add	ress of person who co	ompleted cause of d	eath (Item	23a) (Type, P	rint) へん	CORD	ST #	500) KE	NSIA	UGTON,	MD 2089

State

Registrar

31. Date filed (Month, Day, Year)

3 2008

32 Registrar's Signature

amend line 2 per phy **Physician** /Medical Examiner **Funeral** Director filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f show the Medical Expendence must be notified at Funeral 0 21215-0036 \$ Completed Hygiene. Be ဥ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 aaco hlth dept 06/12/08 dlw For State Registrar 1. Decedent's Name (First, Middle, Last) 06/09/08 2. Date of Death 3. Time of Death Month Doris Wise June 2008 0340 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Elder Care @ Spa Creek Anne Arundel Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec 2.2 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) [946 Marviand 1 □ M 2√2 F 214-46-0465 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel
10e. Street and Number
10. Street and Number 1 dves 2 No Annapolis 10f. Zip Code 10g. Citizen of What Country? 912 B Bloomsbury Square USA 21401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ☐No Specify. Black: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Colonial Cab Co. nd 2 should be filed watth and Mental Hygies 27 Is marked other tirtammatic event, the 0 Cab Driver Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James L. Williams Frances Duvall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If item 27 Is or other tra 21401 912 B Bloomsbury Square Annapolis. Md. Joey Wise(Son) 3altimore. 20a. Method of Disposition Date 20c. Location - City or Town, State 20b Place of Disposition Name of cemetery crematory or other place) Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 6-14-08 Annapolis, Md. U.M. Church 4 ☐ Donation 5 ☐ Other (Specify) AZIName Broading of Secilis Ons Mortuary, 21. Signature of Funeral Service Licensee Larry & Spee Moo483 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 candid **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, attending physician Physician/Medical After this certificate has been signed by the attending properal director, page 2 should be detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ∐ Yes 2 (\$#\$)o Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division or Attending 1 Natural 2 Accident Injury death. hours after death.

uneral Director: A 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral completely filled 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 133036 6/11/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Chick NO 2/6/9 O. of anto 2/18 200 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 2 2008 Registrar

		26 per phy leptr 06/12/08 d lestate Registrar			Ce	rtificate of	Death		Reg of Death	2008	2 0 9 9 1	
Physic /Med		1. Decedent's Name (First, Middle, La Mary Lorraine						June		6ay 200g	5:50 P	
Exami		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location o	of Death		4c. County of Dea	ith	
		1720 St. Marga				Annap			Anne Arundel			
Funeral Director	•	213-20-3312	ex 7. Ag		ast birthday) 77 Yrs.	If Under 1 Year Months Days	Hours	Min. 8. Date (Mon	of Birth th, Day, Y Y 18	^(ear) 1930 1	thplace (State or Foreign ountry) Maryland	
and •		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation					10d. Inside City Limit	
ne Maryla 8a-f sho otiffed at	Director	Maryland Anne A	runde1	Ar	napo				1.40	Citizen of Miles C	1 ☐Wes 2 □ N	
th with the 23a or 2	al Dir	10e. Street and Number 46 Pleasant St	•			10f. Zip Code 2 1 4				USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ I If Yes, Give X			Was Decedent of Hilf Yes, specify Cub 1 ☐ Yes 🏋 No	lispanic Ori an, Mexicar Specify:	gin? (Specify Yes n, Puerto Rican, et	or No- c.)	14. Race - Ame Black, Whi	te, etc.	
72 hour "natural" edical Ex	Completed b	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gra	Year or Dates: ducation ade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	t of working	16	b. Kind of Business	/Industry	
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d be ental ked c	To Be	Horace Thomas					Lor	retta 1	Mari	e Adams		
shoul nd M marl	1	19a. Informant's Name/Relationship	Type. Print)		19b. Maili	ng Address (Street	and Numbe	er or Rural Route i	Number, C	City or Town, State,	Zip Code)	
ulth au 27 is r trau		Gail Ryans(Dau	ghter)		1720	St. Ma	rgars	ets Rd.	Ann	apolis,	Md. 2140	
s 1 al f Hea ftem othe		20a. Method of Disposition		20b. Pla	ace of Dispo	osition (Name of matory or other pla	1	Date		c. Location - City or		
age ent o nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				d Veter		5-12-08	C	rownsvi	lle, Md.	
permit. P Departm Importar any Inju		21. Signature of Funeral Service Lice								ry, P.A Md. 21		
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Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each in	ne.	(INICE	2				Onset and Death	
/Medical		disease or condition resulting in death)	a. Due to (or as	a consequ	ence of):	Nº OZ					ONE YE	
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be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C									
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The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transiti	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	⊒Ectopic pregnand ☐ Other (specify) _	У			23d. Date of de Month	elivery Day Year	
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ding Physician: The n., After this certificate he funeral director, page	Be C	25. Was case referred to medical					26. Place	of Death (Check		3110		
ysic is ce direc	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	ER/Outpatie	nt 3□ DOA Oth	ner: 4□ Nu	rsing Home - 5 2	Hesidem	e 6X□Other (Sp	ecify) daught	
ng Pt ter th neral		27. Manner of Beath 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry v Year)	28b. Time o	f 28c. Inju Wo	ry at rk?	28d. Des	cribe how	injury occurred		
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al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injusting, et	ury - At hor c. <i>(Specify</i>	me, farm, st	reet, factory, office		28f. Loca City	tion (Stre or Town,	et and Number or F State)	Rural Route Number,	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical (nysician: To the best miner: On the basis o and manner st	f examinati								
o the	Ž	29b. Signature and title of certifier	Du		-	29c. Licens	se number	A45	290	I. Date signed (Mon	oth, Day, Year)	
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		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type,	Print)		. 1	Λ	11900215		

			For State	State of M	arylan				nd Mental Hy		8 20997
			Registrar 1. Decedent's Name (First, Middle, La	ist)		Cer	tificate of	Deain	2. Date of De	Reg. No. 200	3. Time of Death
	Physicia	an	Patricia			WI	tenittingt	an	Month	Day Year	2
*	/Medic Examin		4a. Facility Name (If not institution, giv	re street and number)			4b. City, Town, o			4c. County of De	
	LAdimii	ζ,	The Johns Hopkins H	lospital			Baltimore				ore City
	Funeral		Social Security Number 6. 8	Sex 7. Ag		last birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, Da		irthplace (State or Foreign ountry) DF.
	Director		221-42-5235 Usual Residence of Decedent		50	115.			02/20	/1958 W	ilmington
	land		10a. State 10b. County		10c. City	y, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh fied a	ctor	DE New Ca	stle	N	ewark					1 ☐ Yes 2 XNo
	or 28 or 28	Director	10e. Street and Number		11	CWALL	10f. Zip-Code			10g. Citizen of What C	ountry?
	ath wi		119 North Hunt	er Fordg	e Ro	ad	1971			USA	
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces		S. 13.	Vas Decedent of I f Yes, specify Cub	lispanic Origii an, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Am Black, Wh	
36	rs aft	D.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:	INO	1	☐ Yes 2X No	Specify:		Specify: V	White
ğ	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	ted	15. Decedent's E			16a. Deced	lent's Usual Occu kind of work done	pation	of working	16b. Kind of Busines	s/Industry
215	e. an "n Medi	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4 or	5+)	life. L	OO NOT use retire	d)	or working	Educat:	ion
7	ed wi	S	12	4		Ma	nagemer	1	s Name (First, Middle	l	1011
n	tal H	Be	17. Father's Name (First, Middle, Last,	,					ma Nelso		
Maryland 21215-0036	2 should be to and Mental His marked of aumatic ever	၉	John Kennedy 19a. Informant's Name/Relationship	(Type Print)		19b. Mailir	a Address (Street			er, City or Town, State,	Zip Code)
Z	d 2 sl th and th sun traum		David Whitting	For		1				ewark, DE	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		20h P	Place of Dispo	sition (Name of		Date	20c. Location - City of	
ē	Pages nent of int: If its iry or o		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Gr	ace fa	wn Memc	rial	6/11/08	New Cast	cle, DE
Baltimore,	permit. F Departm Importar any Injur	1	21. Signature of Fundral Service Lice	1 1	CC04						
ä	E B E E B		1 Cout 1/2	hh		2	053 Pul	aski	Highway,	f Newark Newark,	DE 19702
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	nplications that cause one cause on each li	d the death ne.	n. Do not ente	er the mode of dyi	ng, such as c	ardiac or respiratory a	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Fulmi	nant	heart	ic faile	re			Onset and Death
	/Medical Examiner		resulting in death)								7
	LAdiminei	-	Sequentially list conditions,	b. Renal							2 Jays
	ed sit	Examiner	Sequentially list conditions, if any local processing control of cause. Enter Underlying Cause (Disease or injury	PI		1	. da (Sugar
	xecut and al-trar	Exa	that initiated events resulting in death) Last	Due to (or as			ctension				3 /6 41.
8760,	cate be executed ohysician and s the burial-transit	edical		d							
687	ificate g phy as th		15 55 M 5								
Box	h cert	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 \subseteq Live birth			Ectopic pregnan	cy		23d. Date of d	
œ.	deat he att	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Onknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5	Other (specify)			Month	Day Year
P.O.	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	Ph	Part II. Other significant conditions	contributing to death	but not res	sulting in the s	inderlying cause o	iven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ŝ	igned	d by	Tak in other organization	John James Commission	Dat 7101 100	, and 19		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 🗆	. /	Probably 4 ☐ Unknown
Ö	w require been sig	Completed					· · · · · · · · · · · · · · · · · · ·		24a. Was	an 24b. Were	autopsy findings available
æ	has t	dmo		-						psy prior to prmed? death	o completion of cause of
Vital Records,			25. Was case referred to medical					26. Place c	1 Ves	2 No 1 Y	es 2 No
È	or Attending Physician: after death. Director: After this certifici in by the funeral director,	To Be	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital: 1 Inpati	ent 2 🗆	ER/Outpatien	t 3 🗆 DOA Oth	or:		dence 6 Other (Sp	ecify)
0	g Phy er this neral d		27. Manner of Death 1	28a. Date of Inju	ıry v Year)	28b. Time o	28c. Inju Wo	ry at rk?	28d. Describe	how injury occurred	
<u>S</u>	Attending Phr er death. ector: After thi by the funeral	atic	2 ☐ Accident investigation	on			M 1	Yes 2 □ No			
Division of	after deal Director:	ertification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		jury - At ho tc. <i>(Specif</i> y	ome, farm, stre /)	eet, factory, office		28f. Location City or Tox	(Street and Number or vn, State)	Rural Route Number,
_	oltai c	0	29a. Certifier 1 FCertifying P	hysician: To the hest	of my know	wiedge, death	occurred at the ti	ime, date and	place, and due to the	cause(s) and manner	as stated
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical			of examinat					, date and place, and o	
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
	- > - 0) to	SOL	in-	· MD/Pá	n RE	-5-0	00	June 4.	2008
	15		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type,	Print)				
	10		Robert	Hayan				6	00 North Wo	olfe St, Baltin	ore, MD, 21287
	Sta Registr	te ar	31. Date filed (Month, Pay Year) 0. 6	2008 32. Registr	ar's Signat	ture	book				
			No.			_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** June /Medical Johnnie Mae 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😡 F Months Days Director 1934 South Carolina 23, 215-30-1668 73 August Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No Director Maryland St. Mary's Chaptico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 23016 Meadow Road 20624 United States filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □ Yes 2√2 No Black 3 Widowed 4 ☐ Divorced Specify: Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 years <u>Housewife</u> Private other permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Lee Bee Willie Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6891 Arbor Lane Bryans Road, Maryland 20616 Felecia Young - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Washington Nat'l Cemt. June 14, 2008 Suitland, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lic-22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebus vascular **Physician** accident /Medical Due to (or as a consequence of): partenion Examiner Sequentially list conditions, if a y, leading to in a diatecause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or all a consequence of): ending physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) I Ves PINO detached the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ As Divation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? /es 2 2 No 1□ Yes or Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ Impatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury Division **₩**atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) mo M.D. 060388

State Registrar Kakhi

31. Date filed (Month, Day, Year)

JUN 1 6 2008

Young

26840

32. Registrar's Signatu

Point Lockout Rd Leonardtown, MD 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishnan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** 8:04АМ м June 13, James Douglas Young /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Lanham Doctor's Hospital Date of Birth (Month, Pay, Year 7/1/1923 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min New York 1 😿 M 2 🗆 F Director 128-22-0203 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show ¬ Is marked other than "natural", or items 23a or 28a-f show
traumatic event, the IN-dical Examiner must be recitived an
traumatic event, the IN-dical Examiner must be recitived an 1 ☐ Yes 2 X No Director Maryland Greenbelt Prince George 10g. Citizen of What Country? 10f. Zip Code 416 Ridge Road Apt.#9 USA 20770 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify. Specify: Black 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Custodial Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f ment of Health and Mental Frederick Young Minnie Davis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; if Item 27 Is any Injury or other trau once. Gloria E. Rufus/Daughter 416 Ridge Road Greenbelt Md. 20770 Apt. #9 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1 Maryland Veterans Cem 6/19/2008 Cheltenham, Md. 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signati of Funeral Service Lice 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Urosepsis /Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and the burial-transit Pneumonia Due to (or as a consequence of): by Physician/Medical attending pl for use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy Year Day 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 ☐ Probably 4 💢 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has director, page 2 autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl. one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 X Natural 2 ☐ Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)

JUN 1 6 2008

30. Name and address of person who complete: cause of death (Item 23a) (Type, Print)

Cecil George, M.D. 7500 Hanover Parkway Suite 101A Greenbelt, Md. 20770

D58182

June 13, 2008

within 24 hours a To the Funeral I 10E.G.

State Registrar

Medical

SYDNEY PO MO 1 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 609 ROOM

PHYSICIAN

and manner stated.

634

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D53590

BRO ADWAY

29d. Date signed (Month, Day, Year)

June 16, 2008

29a. Certifier

29b. Signature and title of certifier